IOWA ADMINISTRATIVE BULLETIN

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PREFACE

The Iowa Administrative Bulletin is published biweekly pursuant to Iowa Code chapters 2B and 17A and contains Notices of Intended Action and rules adopted by state agencies.

It also contains Proclamations and Executive Orders of the Governor which are general and permanent in nature; Regulatory Analyses; effective date delays and objections filed by the Administrative Rules Review Committee; Agenda for monthly Administrative Rules Review Committee meetings; and other materials deemed fitting and proper by the Administrative Rules Review Committee.

The Bulletin may also contain public funds interest rates [12C.6]; usury rates [535.2(3)"a"]; agricultural credit corporation maximum loan rates [535.12]; and other items required by statute to be published in the Bulletin.

PLEASE NOTE: Underscore indicates new material added to existing rules; ~~strike through~~ indicates deleted material.

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Publications Editing Office (Administrative Code) Telephone: 515.281.3355 Email: AdminCode@legis.iowa.gov

CITATION of Administrative Rules

The Iowa Administrative Code shall be cited as (agency identification number) IAC (chapter, rule, subrule, paragraph, subparagraph, or numbered paragraph).

This citation format applies only to external citations to the Iowa Administrative Code or Iowa Administrative Bulletin and does not apply to citations within the Iowa Administrative Code or Iowa Administrative Bulletin.

441 IAC 79	(Chapter)
441 IAC 79.1	(Rule)
441 IAC 79.1(1)	(Subrule)
441 IAC 79.1(1)"a"	(Paragraph)
441 IAC 79.1(1)"a"(1)	(Subparagraph)
441 IAC 79.1(1)"a"(1)"1"	(Numbered paragraph)

The Iowa Administrative Bulletin shall be cited as IAB (volume), (number), (publication date), (page number), (ARC number).

IAB Vol. XII, No. 23 (5/16/90) p. 2050, ARC 872A

Note: In accordance with Iowa Code section 2B.5A, a rule number within the Iowa Administrative Code includes a reference to the statute which the rule is intended to implement: 441—79.1(249A).

The following list will be updated as changes occur.

"Umbrella" agencies and elected officials are set out below at the left-hand margin in CAPITAL letters.

Divisions (boards, commissions, etc.) are indented and set out in lowercase type under their statutory "umbrellas."

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Dec. 18 '24	Jan. 8	Jan. 28	Jan. 31	Feb. 19	Mar. 11	Mar. 26	Mar. 28	Apr. 16	May 21	Aug. 18
Jan. 2	Jan. 22	Feb. 11	Feb. 14	Mar. 5	Mar. 25	Apr. 9	Apr. 11	Apr. 30	June 4	Sep. 1
Jan. 17	Feb. 5	Feb. 25	Feb. 28	Mar. 19	Apr. 8	Apr. 23	Apr. 25	May 14	June 18	Sep. 15
Jan. 31	Feb. 19	Mar. 11	Mar. 14	Apr. 2	Apr. 22	May 7	**May 7**	May 28	July 2	Sep. 29
Feb. 14	Mar. 5	Mar. 25	Mar. 28	Apr. 16	May 6	May 21	May 23	June 11	July 16	Oct. 13
Feb. 28	Mar. 19	Apr. 8	Apr. 11	Apr. 30	May 20	June 4	June 6	June 25	July 30	Oct. 27
Mar. 14	Apr. 2	Apr. 22	Apr. 25	May 14	June 3	June 18	**June 18**	July 9	Aug. 13	Nov. 10
Mar. 28	Apr. 16	May 6	**May 7**	May 28	June 17	July 2	**July 2**	July 23	Aug. 27	Nov. 24
Apr. 11	Apr. 30	May 20	May 23	June 11	July 1	July 16	July 18	Aug. 6	Sep. 10	Dec. 8
Apr. 25	May 14	June 3	June 6	June 25	July 15	July 30	July 31	Aug. 20	Sep. 24	Dec. 22
May 7	May 28	June 17	**June 18**	July 9	July 29	Aug. 13	**Aug. 13**	Sep. 3	Oct. 8	Jan. 5 '26
May 23	June 11	July 1	**July 2**	July 23	Aug. 12	Aug. 27	Aug. 28	Sep. 17	Oct. 22	Jan. 19 '26
June 6	June 25	July 15	July 18	Aug. 6	Aug. 26	Sep. 10	Sep. 11	Oct. 1	Nov. 5	Feb. 2 '26
June 18	July 9	July 29	July 31	Aug. 20	Sep. 9	Sep. 24	Sep. 25	Oct. 15	Nov. 19	Feb. 16 '26
July 2	July 23	Aug. 12	**Aug. 13**	Sep. 3	Sep. 23	Oct. 8	Oct. 9	Oct. 29	Dec. 3	Mar. 2 '26
July 18	Aug. 6	Aug. 26	Aug. 28	Sep. 17	Oct. 7	Oct. 22	**Oct. 22**	Nov. 12	Dec. 17	Mar. 16 '26
July 31	Aug. 20	Sep. 9	Sep. 11	Oct. 1	Oct. 21	Nov. 5	**Nov. 5**	Nov. 26	Dec. 31	Mar. 30 '26
Aug. 13	Sep. 3	Sep. 23	Sep. 25	Oct. 15	Nov. 4	Nov. 19	**Nov. 19**	Dec. 10	Jan. 14 '26	Apr. 13 '26
Aug. 28	Sep. 17	Oct. 7	Oct. 9	Oct. 29	Nov. 18	Dec. 3	**Dec. 3**	Dec. 24	Jan. 28 '26	Apr. 27 '26
Sep. 11	Oct. 1	Oct. 21	**Oct. 22**	Nov. 12	Dec. 2	Dec. 17	**Dec. 17**	Jan. 7 '26	Feb. 11 '26	May 11 '26
Sep. 25	Oct. 15	Nov. 4	**Nov. 5**	Nov. 26	Dec. 16	Dec. 31	**Dec. 31**	Jan. 21 '26	Feb. 25 '26	May 25 '26
Oct. 9	Oct. 29	Nov. 18	**Nov. 19**	Dec. 10	Dec. 30	Jan. 14 '26	Jan. 15 '26	Feb. 4 '26	Mar. 11 '26	June 8 '26
Oct. 22	Nov. 12	Dec. 2	**Dec. 3**	Dec. 24	Jan. 13 '26	Jan. 28 '26	Jan. 29 '26	Feb. 18 '26	Mar. 25 '26	June 22 '26
Nov. 5	Nov. 26	Dec. 16	**Dec. 17**	Jan. 7 '26	Jan. 27 '26	Feb. 11 '26	Feb. 12 '26	Mar. 4 '26	Apr. 8 '26	July 6 '26
Nov. 19	Dec. 10	Dec. 30	**Dec. 31**	Jan. 21 '26	Feb. 10 '26	Feb. 25 '26	Feb. 26 '26	Mar. 18 '26	Apr. 22 '26	July 20 '26
Dec. 3	Dec. 24	Jan. 13 '26	Jan. 15 '26	Feb. 4 '26	Feb. 24 '26	Mar. 11 '26	Mar. 12 '26	Apr. 1 '26	May 6 '26	Aug. 3 '26
Dec. 17	Jan. 7 '26	Jan. 27 '26	Jan. 29 '26	Feb. 18 '26	Mar. 10 '26	Mar. 25 '26	Mar. 26 '26	Apr. 15 '26	May 20 '26	Aug. 17 '26
Dec. 31	Jan. 21 '26	Feb. 10 '26	Feb. 12 '26	Mar. 4 '26	Mar. 24 '26	Apr. 8 '26	Apr. 9 '26	Apr. 29 '26	June 3 '26	Aug. 31 '26

PLEASE NOTE:

Filing deadlines for publication cycles unaffected by holidays have been changed from Friday to Thursday. Rules will not be accepted by the Publications Editing Office after **12 o'clock noon** on the filing deadline unless prior approval has been received from the Administrative Rules Coordinator and the Administrative Code Editor.

If the filing deadline falls on a legal holiday, submissions made on the following business day will be accepted.

†To allow time for review by the Administrative Rules Coordinator prior to the Notice submission deadline, Notices should generally be submitted in RMS four or more business days in advance of the deadline. The first possible notice submission deadline noted above may not allow sufficient time for this. **Agencies should plan accordingly.**

****Note change of filing deadline****

Regulatory Analysis

Notice of Intended Action to be published: 261—Chapter 47
"Endow Iowa Tax Credits"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 15.106A and chapter 15E, subchapter XXII

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 15E, subchapter XXII as amended by 2025 Iowa Acts, Senate File 657

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9:15 to 9:30 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review

Public Comment

Any interested person may submit written comments concerning this Regulatory Analysis, which must be received by the Iowa Economic Development Authority no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Lisa Connell
Iowa Economic Development Authority
1963 Bell Avenue, Suite 200
Des Moines, Iowa 50315
Email: lisa.connell@iowaeda.com

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 47 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to endow Iowa tax credits, available pursuant to Iowa Code chapter 15E, subchapter XXII as amended by 2025 Iowa Acts, Senate File 657. The tax credits encourage investment in community foundations to enhance the quality of life for residents through philanthropic activity.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

Donors applying for or receiving tax credits through the program will bear the costs of the rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Donors applying for or receiving tax credits through the program will benefit from the rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Donors applying for tax credits may require time to complete an application. Community foundations may similarly incur costs to verify donations meet the requirements of the program. The amount of the costs will vary depending on the compensation of staff or service providers involved.

- **Qualitative description of impact:**

The program encourages investment in community foundations to enhance the quality of life for residents through philanthropic activity.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

Authority staff time is required to review and approve applications, issue tax credit certificates, and communicate with donors and community foundations.

- **Anticipated effect on State revenues:**

The rules have no anticipated impact on State revenues. Up to $3.5 million total in tax credits may be authorized by the Authority for this program each year pursuant to Iowa Code section 15E.305(2) as amended by 2025 Iowa Acts, Senate File 657.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Only the entities and individuals that will potentially benefit from the program bear the costs of the rulemaking. The costs to the State to administer the program are proportional to the activities supported.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

The Authority has not identified any less costly methods or less intrusive methods for administering the program.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

The Authority did not consider any other methods.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

The Authority did not consider any other methods.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

The rulemaking impacts only small businesses seeking tax credits. The rules are no more stringent than necessary to implement the purposes of the program. The rules do not establish design or operational standards.

Text of Proposed Rulemaking

ITEM 1. Rescind 261—Chapter 47 and adopt the following **new** chapter in lieu thereof:

CHAPTER 47
ENDOW IOWA TAX CREDITS

261—47.1(15E) Purpose. The purpose of endow Iowa tax credits is to encourage investment in community foundations to enhance the quality of life for residents through philanthropic activity.

261—47.2(15E) Definitions.

"Authority" means the economic development authority created pursuant to Iowa Code section 15.105.

"Community affiliate organization" means the same as defined in Iowa Code section 15E.303 as amended by 2025 Iowa Acts, Senate File 657.

"Corporation or other business entity" means any business organized for profit or a nonprofit entity that includes the name of a business organized for profit.

"Endow Iowa qualified community foundation" means the same as defined in Iowa Code section 15E.303 as amended by 2025 Iowa Acts, Senate File 657.

"Endowment gift" means the same as defined in Iowa Code section 15E.303 as amended by 2025 Iowa Acts, Senate File 657.

"Permanent endowment fund" means a fund held in an endow Iowa qualifying community foundation to provide benefit to charitable causes in the state of Iowa. Endowed funds are intended to exist in perpetuity. "Permanent endowment fund" does not include a fund that contains the name of a corporation or other business entity on or after June 6, 2025.

"Tax credit" means the amount a taxpayer may claim against the taxes imposed in Iowa Code chapter 422, subchapters II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.329.

261—47.3(15E) Authorization of tax credits to taxpayers. The authority shall authorize tax credits to qualified taxpayers pursuant to the provisions of Iowa Code section 15E.305.

47.3(1) If the authority receives applications for tax credits in excess of the amount available pursuant to Iowa Code section 15E.305(2), the applications shall be prioritized by the date the authority received the applications. Applications received on or after July 1, 2023, in excess of the amount of tax credits available will be denied by the authority. For endowment gifts made on or after June 30, 2023, a taxpayer shall submit an application to the authority for the tax credit no later than 12 months from the date of the donation that qualifies the taxpayer for the tax credit.

47.3(2) An individual who intends to claim a tax credit of a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual will only be issued a tax credit if the individual submits an application as an individual. Alternatively, an individual may claim a portion of a tax credit issued to the partnership, limited liability company, S corporation, estate, or trust. The maximum amount of tax credits that may be issued to a taxpayer pursuant to Iowa Code section 15E.305(2)*"a"* will be applied to each tax credit issued, whether issued to an individual or partnership, limited liability company, S corporation, estate, or trust.

47.3(3) For donations made on or after January 1, 2026, the authority will verify that the requirements in Iowa Code section 15E.305(3A) are met prior to issuance of a tax credit. For donations made on or after January 1, 2026, the endow Iowa qualified community foundation that administers a permanent endowment fund for which a taxpayer requests a tax credit must demonstrate that the endow Iowa qualified community foundation does not collect administrative fees or other fees that exceed 5 percent of the amount of any permanent endowment fund it holds.

47.3(4) To receive the tax credit, a donor shall file a claim with the department of revenue in accordance with any applicable administrative rules adopted by the department.

261—47.4(15E) Distribution process and review criteria. The authority shall develop and make available a standardized application pertaining to the allocation of endow Iowa tax credits.

47.4(1) Of the annual amount available for tax credits, 25 percent shall be reserved for those permanent endowment gifts made to community affiliate organizations. If by September 1 of any year the entire 25 percent reserved for permanent endowment gifts corresponding to community affiliate organizations is not allocated, the amount remaining shall be available for other applicants.

47.4(2) The authority will ensure the reservation of tax credits for endowment gifts of $30,000 pursuant to Iowa Code section 15E.305(2)*"b."*

47.4(3) Applications will be accepted and awarded on an ongoing basis. The authority will provide information on tax credit awards on its website.

These rules are intended to implement Iowa Code chapter 15E, subchapter XXII as amended by 2025 Iowa Acts, Senate File 657.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 73
"Managed Care"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50309
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter is the subject of a Red Tape Review pursuant to Executive Order 10. The proposed chapter provides that most Iowa medical assistance program benefits will be provided through managed care.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Medicaid managed care plans, enrollees, and applicants will benefit from the guidance in this proposed chapter.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Almost 700,000 Iowans are covered by Medicaid managed care plans.

- **Qualitative description of impact:**

The proposed rulemaking refines the existing chapter by standardizing the use of acronyms, deleting restrictive terms, and making other perfecting changes.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs in implementing this proposed chapter.

- **Anticipated effect on State revenues:**

There is no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required and appropriate.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 73 and adopt the following **new** chapter in lieu thereof:

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 73
MANAGED CARE

441—73.1(249A) Definitions.

"Appeal" means a review by an MCO or PAHP of an adverse benefit determination as specified in 42 CFR 438.400(b).

"Capitation payment" means a monthly payment to the MCP on behalf of each enrollee for the provision of health or dental 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 MCPs or provider options and answers to related questions and access to personalized assistance to help members understand the

materials provided by the MCPs or the state, to answer questions about each of the options available, and to facilitate enrollment with an MCP.

"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" or *"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, and all references herein are as amended to July 1, 2026.

"Community-based case management" means a collaborative process of planning, facilitation, and advocacy for options and services to meet an enrollee's needs through communication and available resources to promote high-quality, cost-effective outcomes.

"Contract" means a contract between the department and an MCP. These contracts shall meet all applicable requirements of state and federal law, including the requirements of 42 CFR 434.

"Covered services" means physical health, behavioral health, dental, and long-term care services set forth in rule 441—73.5(249A).

"Discharge planning" means the process, which begins at admission, of determining a continued need for treatment services and of developing a plan to address ongoing needs.

"Electronic visit verification system" or *"EVV system"* means an electronic system that providers can check into at the beginning of and check out at the end of each period of service delivery to monitor enrollees' receipt of care.

"Emergency medical condition" means the same as defined in 42 CFR 438.114(a).

"Emergency services" means the same as defined in 42 CFR 438.114(a).

"Enrollee" means a hawki, IHAWP, dental wellness plan or Medicaid member who is eligible for MCP enrollment and has been enrolled with an MCP as described in subrule 73.3(2).

"Enrollment broker" means the entity the department uses to enroll persons in an MCP. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law, including 42 CFR 438.10.

"Hawki 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 as amended to July 1, 2026.

"HIPP" means the health insurance premium payment program.

"Home- and community-based services" or *"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.

"Iowa health and wellness plan" or *"IHAWP"* means the medical assistance program set forth in 441—Chapter 74.

"Level of care" refers to the amount, type, and intensity of medical care services required to meet an individual's health and safety needs.

"Long-term care" or *"LTC"* means the services of a nursing facility (NF); an ICF/ID; the Woodward state resource center; or services funded through Section 1915(c) HCBS waivers, the Section 1915(i) habilitation program, and the PACE program outlined in 441—Chapter 88.

"Managed care organization" or *"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.

"Managed care plan" or *"MCP"* refers to MCOs and PAHPs.

"Mandatory enrollment" means mandatory participation in a managed care plan as specified in subrule 73.3(2).

"Medical loss ratio" means the percentage of capitation payments that is used to pay medical or dental expenses.

"Medically necessary services" means those covered services that are under the terms and conditions of the contract and 42 CFR 438.54(b)(2).

"Member" means any person determined by the department to be eligible for the Medicaid program, hawki program, IHAWP, or dental wellness plan.

"Money Follows the Person (MFP) Rebalancing Demonstration Grant" means a federal grant that will assist Iowa in transitioning individuals from an NF 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 or dental care providers (both individual and group practitioners) linked through contractual arrangements to the MCP to supply a range of health or dental 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 MCP or any of its subcontractors pursuant to the contract between the department and the MCP.

"Participating providers" means the providers of covered physical health, behavioral health, dental, and long-term care services that have contracted with a managed care plan.

"Passive enrollment process" means the process by which the department assigns a member to a managed care plan and that, 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 plans.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2.

"Prior authorization" means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

441—73.2(249A) Contracts with a managed care plan (MCP).

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

73.2(2) The department will determine that the MCP meets the following requirements:

a. The MCP shall make available services to enrollees as established in the contract.

b. The MCP 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 MCP's debts if the MCP becomes insolvent. The MCP shall comply with the insurance division of the Iowa department

of insurance and financial services provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The MCP shall attain and maintain accreditation by the National Committee for Quality Assurance (NCQA) or URAC.

73.2(3) If not already accredited, the MCP 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 MCP must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with 191—Chapter 40.

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 hawki program, IHAWP, and dental wellness plan members shall be subject to mandatory enrollment in an MCP. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in an MCP:

a. Members who are medically needy as described in 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—Chapter 75.

c. Persons who are currently presumptively eligible as defined in 441—Chapter 75.

d. Persons eligible for PACE who voluntarily elect PACE coverage as described in 441—Chapter 88.

e. Persons enrolled in HIPP pursuant to 441—Chapter 75.

f. Persons eligible only for the Medicare savings program as described in 441—Chapters 75 and 76.

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.

h. Persons who have a Medicaid eligibility period that is retroactive as described in 441—Chapter 76.

i. Persons who are inmates of a public institution and ineligible for Medicaid benefits as described in 441—Chapter 75.

j. Persons residing in the Iowa veterans home as described in 801—Chapter 10.

73.3(3) *Enrollment process.* The department will notify members who must be enrolled in an MCP of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438.54.

a. General. Members may receive MCP choice counseling from the enrollment broker. The enrollment broker will provide information about individual MCP 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. Auto-assignment. Effective no earlier than the first day of the month of the member's application to Medicaid, the member will be assigned to an MCP using the department's auto-enrollment process and offered the opportunity to choose from the available MCPs within a time frame specified in the auto-assignment letter.

c. Request to change enrollment. An enrollee may, within 90 days of initial enrollment, request to change enrollment from one MCP and enroll in another MCP. 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 MCP for a total of 12 months.

e. *Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee will be notified of the option to maintain enrollment with the current MCP or to enroll with a different MCP.

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

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

b. The MCP 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.

441—73.4(249A) Disenrollment process.

73.4(1) *Enrollee-requested disenrollment.* An enrollee may request disenrollment with an MCP as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the MCP, 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 MCP, 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 MCP's grievance system. If the member does not experience resolution, the MCP 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 MCP 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 or dental 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 will be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

a. The contract between the department and the MCP is terminated.

b. The enrollee becomes ineligible for Medicaid, the hawki program, IHAWP, or the dental wellness plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the MCP will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care plan enrollment.

d. The department has determined that participation in HIPP as described in 441—Chapter 75 is more cost-effective than enrollment in managed health care.

e. The enrollee dies.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care plan-requested disenrollment.* An MCP shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health or dental care needs or change in health or dental 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. The only exception is when the MCP can document and provide conclusive evidence to the department that the enrollee's continued enrollment seriously impairs the MCP's ability to furnish services to either this particular enrollee or other enrollees. The MCP shall have a multi-level

verification process by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.*

a. The effective date of a department-approved disenrollment will be no later than the first day of the second calendar month beginning after the month in which:

(1) The enrollee requests disenrollment;

(2) The department notifies the enrollee and MCP of disenrollment; or

(3) The MCP requests disenrollment.

b. The enrollee shall remain enrolled in the MCP and the MCP 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 MCO shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

441—73.5(249A) MCP covered services.

73.5(1) *Required services—MCOs.* An MCO shall provide:

a. For all enrolled members, 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 (MFP) Rebalancing Demonstration Grant-funded services.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

73.5(2) *Community-based case management service.* The MCO is required to provide services that meet requirements specified in the contract.

73.5(3) *Value-added services.* An MCP 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.

73.5(4) *Required services—PAHPs.* A PAHP shall provide services to enrollees under the contract with the department and on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates. PAHPs shall provide:

a. For enrollees other than IHAWP enrollees and hawki program enrollees, services as set forth in 441—Chapters 73, 74, 78, and 88 with the exception of the following:

(1) Area education agency services.

(2) Inpatient hospital or institutional services.

(3) Advance directive requirements in dental nonclinical services such as transportation.

(4) Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, the Woodward state resource center, or ICFs/ID).

(5) Inpatient psychiatric care provided at the state-administered mental health institutes.

(6) Services provided at specialized adolescent psychiatric facilities.

(7) Day treatment and partial hospitalization services for persons aged 20 or under.

(8) Enhanced services provided to certain eligible recipients.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

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

73.6(1) The MCP shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the department. In accordance with federal funding

requirements, including 42 CFR 438.210(a)(3), the MCP shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The MCP shall 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, as a condition of payment, the MCO shall provide prior authorization for any admissions to an NF, an ICF/ID, a psychiatric medical institution for children (PMIC), and a state-administered mental health institute. Prior MCO approval is also required for all out-of-state placements.

73.6(2) The MCP 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 MCP shall not:

a. Avoid costs for services covered in the contract by referring members to publicly supported health or dental care resources.

b. Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The MCP shall allow each enrollee to choose a health or dental professional, to the extent possible and appropriate, within the MCP's provider network. The MCP shall ensure compliance with the Americans with Disabilities Act (ADA) as amended to July 1, 2026, in the delivery and approval of all services.

441—73.7(249A) Emergency services.

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

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114, the MCP shall:

a. Cover emergency services without the need for prior authorization and shall not limit reimbursement to network providers.

b. Cover and pay for emergency services regardless of whether the provider that furnishes the services is enrolled with Iowa Medicaid or has a contract with the MCP.

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 provided to a member who presents to an emergency department with an emergency medical condition. This requirement applies to MCOs only.

73.7(3) The MCP shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition.

b. Treatment obtained when a representative of the MCP instructs the enrollee to seek emergency medical services.

441—73.8(249A) Access to service.

73.8(1) The MCP shall ensure enrollees have access to services as specified in the contract. The MCP 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, seven-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 or dental 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 MCP's provider network unless the MCP 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), the MCO shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers that are not in the MCP network.

73.8(3) Continuity of care. The MCP 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 MCP 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 MCP shall maintain a dedicated toll-free enrollee 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 MCP departments, such as care coordinators.

b. Nurse call line. The MCO shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, seven days a week from trained medical professionals.

73.8(5) The MCP shall ensure that network providers are responsible for providing preventive and primary health or dental care to the enrollee. Primary care providers shall initiate referrals for specialist care, where appropriate, and maintain 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.

441—73.9(249A) Incident reporting.

73.9(1) The MCO 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; for the Section 1915(i) habilitation program; and as required for licensure of programs through the department of inspections, appeals, and licensing.

73.9(2) The MCO shall develop and implement policies and procedures, subject to department review and approval, to:

a. Address and respond to incidents;

b. Report incidents to the appropriate entities in accordance with required time frames; and

c. Track and analyze incidents.

441—73.10(249A) Discharge planning. The MCO shall establish policies and procedures, subject to approval by the department, that protect an enrollee from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The MCO shall facilitate a seamless transition whenever an enrollee transitions between facilities or residences.

441—73.11(249A) Level of care (LOC) assessment.

73.11(1) The department will retain full authority to determine whether the Medicaid LOC or needs-based assessment has been completed in a timely manner by the appointed vendor. The MCO will be notified once an enrolled member's LOC determination has been completed. The LOC and needs-based eligibility assessment process and the requirements are provided in 441—Chapters 75, 78, 81, 82, 83, and 85. HCBS waiver LOC determinations must be consistent with those made for the appropriate institutional LOC under the state plan.

73.11(2) At any time, if the MCO becomes aware the enrollee's functional or medical status has changed in a way that may affect LOC or needs-based eligibility, the MCO shall submit documentation to the department's appointed vendor to conduct an LOC or needs-based assessment. The department-approved tools shall be used to conduct an updated assessment. The updated assessment shall then be submitted to the department for determination of LOC or needs-based eligibility.

441—73.12(249A) Appeal of MCP actions. The MCPs shall have written first-level appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal an MCP action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438, Subpart F.

73.12(1) *MCP appealable actions.* MCP actions that may be appealed by an enrollee may include, as cited in 42 CFR 438.400(b):

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 described by the department.

e. Failure to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b).

f. Denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCP's network related to rural access or capacity.

g. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

73.12(2) *Appeal process.* The MCP first-level appeal process will be approved by the department and shall:

a. Allow for the appeal request to be submitted in writing or verbally.

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.

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.

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the MCP through the MCP's first-level appeal process, the enrollee may file an appeal with the department. This process is referred to as a state fair hearing, an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 and federal requirements for a state fair hearing in 42 CFR 438.408(f).

441—73.14(249A) Continuation of benefits. The MCP shall be required to continue the member's benefits during any appeal in accordance with federal funding requirements, including 42 CFR 438.420.

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 calendar days pass after the MCP mailed the notice providing the resolution of the appeal against the enrollee unless the enrollee, within the ten-calendar-day time frame, requests 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 are met.

73.14(2) If the final resolution of the state fair hearing is adverse to the enrollee, that is, it upholds the MCP's action, the MCP may recover the cost of the services furnished to the enrollee

while the appeal was pending, to the extent services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the MCP or state fair hearing administrative law judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize and provide the disputed services promptly and as expeditiously as the member's health or dental condition requires. If the MCP or the state fair hearing ALJ reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the MCP must pay for these services.

441—73.15(249A) Grievances. The MCP shall have policies and procedures for reviewing expressions of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to quality of care or services provided, aspects of interpersonal relations such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested pursuant to 42 CFR 438.400(b). 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.

441—73.16(249A) Written record. All MCP 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 pursuant to 42 CFR 438.416.

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

441—73.18(249A) Records and reports.

73.18(1) *Records system.* The MCPs shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including 441—Chapter 79 and 42 CFR 456, 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 MCP based upon medical necessity.

c. Permit effective professional review for medical audit processes.

d. Facilitate an adequate system for monitoring treatment reimbursed by the MCO, including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) *Content of individual treatment record.* The MCP shall ensure that participating providers maintain an adequate recordkeeping system that includes a complete medical, dental, or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of 441—Chapter 79 and pursuant to federal funding requirements, including 42 CFR 456. MCOs shall require use of an EVV system for personal care services.

73.18(3) *Confidentiality of health care, mental health care, and substance abuse information.* The MCP shall protect and maintain the confidentiality of all protected health information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

73.18(4) *EVV system.* The MCO will participate in EVV planning activities and use the MCO-proposed, department-approved EVV system that will be in place within a time frame determined by the department to ensure compliance with state and federal regulations, including Section 12006 of the Cures Act (42 U.S.C. §1396b(1) as amended to July 1, 2026). Beginning on the dates required

by the department, the MCO shall require personal care providers and home health services to use the MCO EVV system or another EVV system complying with Section 12006 of the Cures Act as amended to July 1, 2026. The MCO shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, home health services, and other services using the EVV system. All EVV data that originates in or passes through the MCO EVV system will be provided to the department in a format and time frame subject to department approval.

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 MCP. The department or HHS may audit and inspect any records of an MCP, or the subcontractor of the MCP, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, at places, and in a manner as authorized representatives of the department or its designee as HHS may request.

441—73.20(249A) Marketing. MCP marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the MCP and contract terms. The department will approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104.

441—73.21(249A) Enrollee education.

73.21(1) *Use of services.* The MCP shall provide written information to all enrollees on the use of the services the MCP 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 MCP decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7; how to access the state 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 MCP shall provide enhanced outreach to members with special needs, including but not limited to persons with a psychiatric disability, an intellectual disability or other cognitive impairments; illiterate persons; non-English-speaking persons; and persons with visual impairments or who are deaf or hard of hearing.

73.21(3) *Patient rights and responsibilities.* The MCP shall have in effect a written statement of patient rights and responsibilities that 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.

441—73.22(249A) Payment to the MCP.

73.22(1) *Capitation rate.* In consideration for all services rendered by an MCP under a contract with the department, the MCP 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 described in the MCP contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act as amended to July 1, 2026, regarding the health insurance provider's fee. This capitation rate, inclusive of the amounts withheld and the health insurance provider's 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 MCP meets metrics described in the MCP 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, Actuarial Standards

of Practice 49, as amended to July 1, 2026, 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 or dental expenses, it is the right and responsibility of the MCP to investigate these third-party resources and attempt to obtain payment.

a. The MCP shall have a time limit determined by the department to attempt to collect from third-party resources.

b. The MCP shall retain all funds collected from third-party resources during the time limit.

c. A complete record of all third-party collections must be maintained and made available to the department on request.

d. In the event that the MCP no longer contracts with the department, the department has the right to seek recovery of any third-party collections not collected by the time the contract ends and retain the funds. This includes but is not limited to subrogation cases.

e. The department has the right to retain all funds collected from third-party resources after the MCP time limit.

73.22(4) *Medical loss ratio.* The MCP 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 MCP.

441—73.23(249A) Claims payment by the MCP.

73.23(1) The MCOs shall pay or deny:

a. Ninety percent of all clean claims within 30 calendar days of receipt,

b. Ninety-nine point five percent of all clean claims within 90 calendar days of receipt, and

c. Ninety-five percent of all claims within 45 calendar days of receipt.

73.23(2) The PAHP shall pay or deny:

a. Ninety percent of all clean claims within 14 calendar days of receipt,

b. Ninety-nine percent of all clean claims within 90 calendar days of receipt, and

c. Ninety-five percent of all claims within 21 calendar days of receipt.

73.23(3) Managed care limits on payment responsibility for services.

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

b. The MCP 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 in rule 441—73.7(249A).

73.23(4) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the MCO is obligated to pay 80 percent of the payment to participating providers.

73.23(5) Timely filing. The in-network provider filing limit shall be no more than 180 days from the date of service.

441—73.24(249A) Quality assurance. The MCP 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.

441—73.25(249A) Certifications and program integrity. The MCP 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 MCP shall cooperate and collaborate with the department on all program integrity activities. The MCP shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455.

These rules are intended to implement Iowa Code section 249A.4.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 74
"Iowa Health and Wellness Plan"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A and 249N
State or federal law(s) implemented by the rulemaking: Iowa Code chapters 249A and 249N

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter defines and structures the Iowa Health and Wellness Plan, a medical assistance program for individuals with countable income that does not exceed 133 percent of the federal poverty level. This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result, the Department removed duplicative, redundant, and outdated language and information. In addition, the Department is changing the due date for financial participation payments from the last day of the month to the fifteenth day of the month.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Individuals who are covered by or eligible for the Iowa Health and Wellness Plan will benefit from the guidance in this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Almost 186,000 people were enrolled in the Iowa Health and Wellness Plan as of June 2025.

- **Qualitative description of impact:**

This proposed chapter defines and structures the Iowa Health and Wellness Plan, a medical assistance program for individuals with countable income that does not exceed 133 percent of the federal poverty level.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

This proposed rulemaking has no effect on State revenues. The underlying program has a fiscal impact to the State. Information on historical expenditure will be submitted to the Legislative Services Agency with the Notice of Intended Action.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required by Iowa Code chapter 249N.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 74 and adopt the following **new** chapter in lieu thereof:

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

441—74.1(249A,249N) Definitions. The following definitions apply to this chapter in addition to the definitions in 441—Chapter 75.

"Caretaker" means the same as defined in rule 441—75.1(249A).

"Countable income" means "modified adjusted gross income" (MAGI) or "household income," as applicable, determined pursuant to 42 U.S.C. §1396a(e)(14) as amended to July 1, 2026.

"Enrollment period" means the period of time for which Iowa health and wellness plan eligibility is established.

"Essential health benefits" means the essential health benefits defined at 42 U.S.C. §18022 as amended to July 1, 2026.

"Iowa dental wellness plan" means the managed care dental benefit program set forth in 441—Chapter 73.

"Iowa health and wellness plan" or *"IHAWP"* means the medical assistance program set forth in this chapter for individuals with countable income that does not exceed 133 percent of the federal poverty level (FPL).

"Iowa wellness plan" means the benefits and services provided to IHAWP members.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical assistance" or *"Medicaid"* means payment of all parts of the cost of the care and services made in accordance with Title XIX of the Federal Social Security Act as amended to July 1, 2026.

"Medically frail individual" means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR 440.315 as amended to July 1, 2026.

"Minimum essential coverage" means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code as amended to July 1, 2026.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2 as amended to July 1, 2026.

"Qualified employer-sponsored coverage" is defined pursuant to 42 U.S.C. §1396e1(b) as amended to July 1, 2026.

441—74.2(249A,249N) Eligibility factors. Except as more specifically provided in this chapter, IHAWP eligibility will be determined according to the requirements of 441—Chapter 75.

74.2(1) *Persons covered.* Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under IHAWP will be available to persons 19 through 64 years of age who:

a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;

b. Have countable income at or below 133 percent of the FPL for their household size;

c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act as amended to July 1, 2026; and

d. Are not pregnant at the time of application or reenrollment.

74.2(2) *Parents or caretakers of dependent children.* All children under the age of 21 living with a parent or caretaker who will be claimed as a dependent by the parent or caretaker for state or federal income tax purposes must be enrolled in Medicaid, in the Children's Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent's or caretaker's eligibility for IHAWP benefits.

74.2(3) *Citizenship.* To be eligible for IHAWP benefits, a person must meet the citizenship requirements in 441—Chapter 75.

441—74.3(249A,249N) Application. Medicaid application policies and procedures described in 441—Chapter 76 apply to applications for IHAWP.

441—74.4(249A,249N) Financial eligibility.

74.4(1) *Countable income.* Individuals are financially eligible for IHAWP if their countable income is no more than 133 percent of the FPL as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size will be determined according to the MAGI methodology.

441—74.5(249A,249N) Enrollment period.

74.5(1) *Effective dates of eligibility.* IHAWP eligibility will be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later.

74.5(2) *Reinstatement.* Enrollment for IHAWP may be reinstated without a new application in accordance with 441—Chapter 76.

74.5(3) *Presumptive eligibility.* The enrollment period is based on a presumptive eligibility determination by a qualified entity in accordance with 441—Chapter 76.

74.5(4) *Retroactive enrollment.* Medical assistance will be available to a pregnant woman or an infant (under one year of age), or a resident of a nursing facility licensed under Iowa Code chapter 135C, for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—Chapter 76.

441—74.6(249A,249N) Reporting changes.

74.6(1) *Reporting requirements.* In addition to the reporting requirements in 441—Chapter 76, as a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member turns 65.

d. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.

e. A child under the age of 21 living with the member loses minimum essential coverage if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.

f. The member is pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible will be considered an overpayment and be subject to recovery from the member in accordance with 441—Chapters 75 and 11. Program expenditures may include but are not limited to premiums and capitation payments.

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility will be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in rule 441—16.2(17A); or

b. The enrollment period has expired and the member is not eligible for a new enrollment period.

441—74.7(249A,249N) Reenrollment. A new eligibility determination is required to establish an enrollment period. The reenrollment process will follow the requirements in 441—Chapter 76.

441—74.8(249A,249N) Terminating enrollment. IHAWP enrollment ends when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.

2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.

3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the FPL.
10. IHAWP is discontinued according to the requirements in rule 441—74.14(249A,249N).
11. The member does not pay monthly contributions as required by subrule 74.11(2).

441—74.9(249A,249N) Recovery. The department will recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—Chapter 75.

74.9(1) The department will recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—Chapter 75.

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the department or the MCO, and an adjustment will be made to a previously submitted claim.

441—74.10(249A,249N) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed to the extent permitted by 441—Chapter 7.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,249N).

441—74.11(249A) Financial participation.

74.11(1) *Copayment.* Payment for nonemergency use of a hospital emergency department shall be subject to an $8 copayment by the member, which will be subtracted from the IHAWP payment otherwise due to the provider.

74.11(2) *Monthly contributions.* Members enrolled in the IHAWP with household income at or above 50 percent of the FPL are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to 441—Chapter 75, as a percentage of the FPL for the household. Monthly contribution amounts are as follows:

(1) For a member with household income between 50 and 100 percent of the FPL, $5;

(2) For a member with household income above 100 percent of the FPL, $10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

(1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.

(2) The member is determined by the department to be a medically frail individual pursuant to subrule 74.12(2).

(3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.

(4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as amended to July 1, 2026, as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning Iowa Medicaid member services, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted. Members must complete the process in every month for which they wish to claim financial hardship. There is no limit to the number of hardship exemptions for which a member may apply.

d. Billing and payment. An Iowa Medicaid billing statement form will be used for billing and collection of the monthly contribution.

(1) Method of payment. Members shall submit contribution payments to the address specified by the department. Members can also submit contributions through the department's website.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution is due on the fifteenth day of the month in which the statement is received.

2. If the fifteenth day of the month falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department will apply monthly contribution payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department will hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An IHAWP member with household income between 50 and 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) An IHAWP member with household income above 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) will have the member's eligibility terminated. In addition, the member shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions may reenroll for Medicaid benefits pursuant to 441—Chapter 76.

3. Unpaid premiums will not be considered a collectible debt by the state if, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment.

f. Refund of monthly contributions.

(1) Monthly contributions paid may be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2)*"c"* or when a member's IHAWP coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in IHAWP; or

2. The member dies.

(2) The amount of any refund will be offset by any outstanding monthly contributions owed.

(3) The refund will be paid within two calendar months from the date of termination from the program.

74.11(3) *Aggregate annual limits on copayments and monthly contributions.* The total aggregate annual amount of copayments and monthly contributions for an individual will not exceed 5 percent of the household's countable annual income determined pursuant to 441—Chapter 75.

74.11(4) *Healthy behaviors.* An IHAWP member who completes a wellness examination and health risk assessment during any enrollment year will have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dental provider consistent with standard oral health guidelines for preventive dental examinations and as outlined in 441—Chapter 73.

b. A health risk assessment is an assessment offered by a managed care plan through which the member is receiving IHAWP benefits.

441—74.12(249A) Benefits and service delivery. Covered benefits and the service delivery method will be determined by the member's health status.

74.12(1) *Iowa wellness plan services.* Members shall be enrolled in IHAWP unless the member is determined by the department to be a medically frail individual.

a. Covered Iowa wellness plan services are essential health benefits; all other benefits required pursuant to 42 U.S.C. §1396u-7(b)(1)(B) as amended to July 1, 2026, including prescription drugs; and dental services consistent with 441—Chapter 78.

b. Members enrolled in IHAWP shall be subject to enrollment in managed care, other than program for all-inclusive care for the elderly (PACE) programs, pursuant to 441—Chapter 73.

c. Dental services will be provided under the Iowa dental wellness plan as set forth in 441—Chapter 73 through a contract with one or more dental prepaid ambulatory health plans. The dental prepaid ambulatory health plan shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) *Medically frail individuals.* An IHAWP member who has been determined by the department to be a medically frail individual will be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A provider with a current national provider identifier number, an employee of the department, a designee of the department of corrections, an MCO, a behavioral health administrative service organization established pursuant to Iowa Code chapter 225A, or a disability access point established pursuant to Iowa Code chapter 231 may refer a member for a medically frail individual determination by submitting a completed form prescribed by the department.

b. Upon receipt of the appropriate forms, the department will determine whether the member qualifies as a medically frail individual in accordance with 42 CFR 440.315 as amended to July 1, 2026.

74.12(3) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective, employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

441—74.13(249A,249N) Claims and reimbursement methodologies. Payment for services provided under the Iowa wellness plan services will be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member's MCO and the provider.

441—74.14(249A,249N) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for IHAWP is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services will be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

These rules are intended to implement Iowa Code chapters 249A and 249N.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 77
"Conditions of Participation for Providers of Medical and Remedial Care"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines the qualifications needed for providers to participate in Iowa's Medical Assistance Program.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of the Department's review, the Department added or updated dates certain, replaced restrictive terms with less restrictive alternatives, referred language duplicative of federal regulations back to the Code of Federal Regulations, replaced outdated terminology with current terminology, referred items to the appropriate provider manuals, consolidated references to like services, renumbered, and standardized the use of acronyms.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Health care providers that want to participate in Iowa's Medical Assistance Program will benefit from this proposed chapter.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

There are 72,358 providers participating in Iowa's Medical Assistance Program.

- **Qualitative description of impact:**

Health care providers that want to participate in Iowa's Medical Assistance Program will benefit from this proposed chapter.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

This proposed chapter has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required by law.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Rulemaking is required by law.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

No other methods were considered by the Department.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Rulemaking is required by law.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 77 and adopt the following **new** chapter in lieu thereof:

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs will be held confidential.

441—77.3(249A) Pharmacists. An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.

441—77.4(249A) Hospitals.

77.4(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.4(2) *Psychiatric bed tracking system.* As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

a. Definitions.

"Adult beds" means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

"Child beds" means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

"Geriatric beds" means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.

"Hospital," for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

"Psychiatric bed tracking system" means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

b. Hospitals are required to participate in the psychiatric bed tracking system.

c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.

d. Each update must include the number of child beds by sex, the number of adult beds by sex, and the number of geriatric beds by sex.

e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

441—77.5(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state. Note, however, that payment will not be made to a dental laboratory.

441—77.6(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.8(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.9(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate provided that they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) as amended to July 1, 2026, by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act as amended to July 1, 2026.

441—77.10(249A) Home health agencies. Home health agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and, unless otherwise exempted, have submitted a surety bond as required by subrules 77.10(2) through 77.10(4).

77.10(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.10(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the department as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 through 9308 and 31 CFR Part 223, both as amended to July 1, 2026, and 31 CFR Parts 224 and 225, both as amended to July 1, 2026. The bond shall list the surety's name, street address or post office box number; city; state; and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department will give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety

companies determined by the department to be unauthorized in Iowa will be maintained and will be available for public inspection by contacting the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.10(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.10(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with 42 CFR 484 Subparts A, B, and C as amended to July 1, 2026, and with the Medicare Program Integrity Manual, Chapter 10.2.5.3, as amended to July 1, 2026.

441—77.11(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.12(249A) Ambulance service. Providers of ambulance service are eligible to participate provided that they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and Iowa Code section 147A.8.

441—77.13(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited: by one of the following bodies:

1. The Joint Commission (TJC) accreditation, or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24.

441—77.14(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

441—77.15(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

441—77.16(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they are accredited pursuant to 441—Chapter 24.

441—77.17(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in rule 441—78.18(249A) and meet the department's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the department.

441—77.18(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice, and are eligible to participate in the Medicare program.

441—77.19(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

441—77.20(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).

441—77.21(249A) Independent laboratories. Independent laboratories are eligible to participate provided that they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

441—77.22(249A) Rural health clinics. Rural health clinics are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).

441—77.23(249A) Psychologists.

77.23(1) All psychologists licensed to practice in the state of Iowa pursuant to Iowa Code chapter 154B are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the credentialing requirements of the National Register of Health Service Psychologists as amended to July 1, 2026.

77.23(2) A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

77.23(3) A psychologist provisionally licensed in another state is eligible to participate when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

441—77.24(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A) for more information). The prenatal and postpartum care shall be in accordance with the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services, as amended to July 1, 2026.

441—77.25(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if the ambulatory surgical centers are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 481—Chapter 579 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.26(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of the federally qualified health centers' eligibility as allowed by Section 6404(b) of Public Law 101–239 as amended to July 1, 2026.

441—77.27(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to 481—Chapter 621.

77.27(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with 481—Chapter 621.

77.27(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.27(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

441—77.28(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.28(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.28(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

441—77.29(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation.

441—77.30(249A) HCBS habilitation services. To be eligible to participate in the Medicaid program as an approved provider of HCBS habilitation services, a provider shall meet the general requirements in subrules 77.30(2) through 77.30(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.30(1) *Definitions.*

"Certified employment specialist" or *"CES"* means a person who has earned a CES certification through a nationally recognized accrediting body.

"Guardian" means a guardian appointed in probate or juvenile court.

"Home- and community-based services" or *"HCBS"* means the types of person-centered care delivered in the home and community.

"Immediate family member" means any of the following:

(1) Husband or wife.
(2) Natural or adoptive parent, child, or sibling.
(3) Stepparent, stepchild, stepbrother, or stepsister.
(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
(5) Grandparent or grandchild.
(6) Spouse of grandparent or grandchild.

"Individual employment" means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job and for which the member is paid at or above minimum wage but not less than the customary wage and

level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Individual placement and support" or *"IPS"* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions.

"IPS 25-item supported employment fidelity scale" means the fidelity scale published by the IPS Employment Center as amended to July 1, 2026, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

"IPS implementation" means the process advocated by the IPS Employment Center as amended to July 1, 2026.

"IPS reviewer" means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of "good" or better; has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS reviewer; and has shadowed one or more IPS fidelity reviews;
2. An existing IPS reviewer from a state that is a member of the IPS International Learning Collaborative;
3. An IPS reviewer contracted directly from the IPS Employment Center;
4. A CES with a bachelor's degree who has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

"IPS team" means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

"IPS trainer" means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of "good" or better and has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS trainer;
2. An existing IPS trainer from a state that is a member of the IPS International Learning Collaborative;
3. An IPS trainer contracted directly from the IPS Employment Center;
4. A CES with a bachelor's degree who has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS trainer.

"Managed care organization" or *"MCO"* means the same as defined in 441—Chapter 73.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association as amended to July 1, 2026, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the DSM published by the American Psychiatric Association as amended to July 1, 2026.

"Prospective IPS team" means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a as amended to July 1, 2026.

"Provider-owned or controlled setting" means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord/tenant laws do not apply, the state will ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

"Provisionally approved IPS team" means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a as amended to July 1, 2026, and (3) begun to deliver IPS services.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder in a child under 18 that significantly impairs the child's ability to function in family, school, or community settings. This impairment must be substantial and have lasted long enough to meet specific diagnostic criteria outlined in the DSM as amended to July 1, 2026.

"Severe and persistent mental illness" or *"SPMI"* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles.

77.30(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.30(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS habilitation provider manual as amended to July 1, 2026.

77.30(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.30(5) *Residential and nonresidential settings.* All HCBS, whether residential or nonresidential, shall be provided in accordance with 42 CFR 441.301(4) and (5) as amended to July 1, 2026.

77.30(6) *Case management.* A provider is eligible to participate in the HCBS habilitation program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.30(7) *Day habilitation.*

a. The following providers may provide day habilitation:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by CARF to provide other services and has begun providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7)*"a"*(1), *"a"*(4), or *"a"*(7).

(3) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by the Joint Commission.

b. Direct support staff providing day habilitation services shall meet the qualifications as outlined in the HCBS Manual as amended to July 1, 2026.

77.30(8) *Home-based habilitation.*

a. The following agencies may provide home-based habilitation services:

(1) An agency that is certified by the department to provide supported community living services under:

1. The HCBS intellectual disability waiver pursuant to rule 441—77.40(249A); or
2. The HCBS brain injury waiver pursuant to rule 441—77.42(249A).

(2) An agency that is accredited under 441—Chapter 24 to provide supported community living services.

(3) An agency that is accredited by CARF as a community housing or supported living service provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that is accredited by the Council on Accreditation of Services for Families and Children.

(6) An agency that is accredited by the Joint Commission.

b. Agencies meeting the criteria under subrule 77.30(9) or 77.40(2) that seek certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A certified intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) home-based habilitation provider in good standing with Iowa Medicaid.

(2) Provide staffing 24 hours per day, 7 days per week, 365 days per year.

(3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served.

(4) Ensure that all staff members have the qualifications outlined in the HCBS Manual as amended to July 1, 2026.

(5) Ensure that within the first year of employment, staff members complete 48 hours of training in the subject matter outlined in the HCBS Manual as amended to July 1, 2026.

(6) Provide coordination with the individual's clinical mental health and physical health treatment and other services and supports.

(7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual and any other plans developed for the individual.

(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services.

(9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.

(10) Accept and serve eligible individuals who are court-ordered to intensive residential services.

(11) Provide services to eligible individuals on a no-reject, no-eject basis.

(12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from the department.

(13) Be located in a neighborhood setting to maximize community integration and natural supports.

(14) Demonstrate specialization in serving individuals with a serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same site.

c. Direct support staff providing home-based habilitation services shall meet the qualifications outlined in the HCBS Habilitation Manual as amended to July 1, 2026.

d. The department will approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

e. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area; and

(2) The county in which the living unit is located provides to the department verification in writing that approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need; or
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.30(9) *Prevocational habilitation.*

a. The following providers may provide prevocational services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall, within six months of hire, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE)-certified training program as amended to July 1, 2026.

(3) Prevocational direct support staff shall complete four hours of continuing education in employment services annually.

77.30(10) *Supported employment habilitation.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(3) An agency that is accredited by CARF to provide other services and began providing services that qualify as supported employment under 441—subrule 78.27(10) since the agency's last accreditation survey. The agency may provide supported employment services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.30(10)*"a"*(1), *"a"*(2), *"a"*(5), *"a"*(6), *"a"*(7) or *"a"*(8).

(4) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(5) An agency that is accredited by the Council on Accreditation.

(6) An agency that is accredited by the Joint Commission.

(7) An agency that is accredited by the Council on Quality and Leadership.

(8) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council on Quality and Leadership in Supports for People with Disabilities is no longer a qualified provider.

(9) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the qualifications outlined in the HCBS Habilitation Manual and HCBS Waiver Manual, both as amended to July 1, 2026.

d. Providers qualified to offer IPS services shall meet the following requirements:

(1) Providers shall meet the provider qualifications listed in this subrule.

(2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.

(3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.

(4) Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.

(5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.30(1).

(6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a "fair" score on a baseline fidelity review completed by IPS reviewers.

(7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a as amended to July 1, 2026, within 12 months of enrolling.

(8) Upon completion of IPS implementation phase 4a as amended to July 1, 2026, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.

(9) Upon completion of IPS implementation phase 7 as amended to July 1, 2026, IPS teams are qualified to deliver IPS services, subject to the following:

1. IPS teams must obtain a baseline fidelity review score of "fair" or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.

2. In the event an IPS team fails to achieve a fidelity score of "fair" or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than "fair" fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches "fair" fidelity, whichever date is earliest.

3. IPS teams who do not achieve a "fair" fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum "fair" fidelity score.

441—77.31(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.31(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral health professionals as a marital and family therapist pursuant to 481—Chapter 880 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.31(2) *Temporarily licensed marital and family therapists.* Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.

77.31(3) *Licensed independent-level social workers (LISW).* Any person licensed by the board of social work as an independent-level social worker pursuant to 481—Chapter 880 is eligible to participate. An independent-level social worker in another state is eligible to participate when duly licensed to practice in that state.

77.31(4) *Licensed master-level social workers (LMSW).*

a. A person licensed by the board of social work as a master-level social worker pursuant to 481—Chapter 880 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent-level social worker licensed pursuant to 481—Chapter 880.

b. A master-level social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent-level social worker duly licensed in that state.

77.31(5) *Licensed mental health providers (LMP).* Any person licensed by the board of behavioral health professionals as a mental health provider pursuant to Iowa Code chapter 154D and 481—Chapter 880 is eligible to participate. A mental health provider in another state is eligible to participate when duly licensed to practice in that state.

77.31(6) *Temporarily licensed mental health counselors.* Any person temporarily licensed by the board of behavioral health professionals as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides

treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

77.31(7) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of certification as an alcohol and drug counselor is eligible to participate.

77.31(8) *Licensed behavior analysts.* Any person licensed by the board of psychology as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

77.31(9) *Licensed assistant behavior analysts.* A person licensed by the board of psychology as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:

a. Holds current certification as an assistant behavior analyst by a certifying entity; and

b. Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

77.31(10) *Registered behavior technicians.*

a. A person is eligible to participate as a registered behavior technician when the person holds:

(1) A current certification from the behavior science board as a registered behavior technician; or

(2) A bachelor's degree.

b. A registered behavior technician must provide treatment under the supervision of a behavior analyst or assistant behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

441—77.32(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

441—77.33(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.33(1) Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

77.33(2) Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

77.33(3) Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

77.33(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

b. Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

c. Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

d. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

e. Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

77.33(5) Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

77.33(6) Personnel providing vision services shall be:

a. Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

b. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

c. Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

441—77.34(249A) Case management provider organizations. Case management provider organizations meeting the criteria in 441—Chapter 24 are eligible to participate.

441—77.35(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by an agency meeting the standards and qualifications pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.35(18) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided.

77.35(1) *Home maintenance providers.* Home maintenance providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

77.35(2) *Home health aide providers.* Home health aide providers shall be agencies that are certified to participate in the Medicare program.

77.35(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections, appeals, and licensing (DIAL) as being in compliance with the standards for adult day services programs in 481—Chapter 70.

77.35(4) *Nursing care providers.* Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.35(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Hospitals licensed pursuant to 481—Chapter 51.

(3) Nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 through 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home maintenance providers that meet the conditions of participation set forth in subrule 77.35(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.35(3).

(8) Residential care facilities for individuals with intellectual disabilities licensed by DIAL.

(9) Assisted living programs certified by DIAL.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The member's name, birth date, age, and address and the telephone number of each parent, guardian, or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers, such as the number of the member's physician and the parents, guardian, or primary caregiver.

4. The member's medical issues, including allergies.

5. The member's daily schedule that includes the member's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.35(6) *Counseling providers.* Counseling providers shall be:

a. Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

b. Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

77.35(7) *Attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. Agencies authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

b. Home health agencies that are certified to participate in the Medicare program.

c. Community action agencies as designated in Iowa Code section 216A.93.

d. Providers certified under an HCBS waiver for supported community living.

e. Assisted living programs that are certified by DIAL under 481—Chapter 69.

f. Adult day service providers that are certified by DIAL under 481—Chapter 70.

g. Community businesses that are engaged in the provision of attendant care services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.35(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.40(2) or 77.42(12).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

77.35(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 441—Chapter 226.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation coverage.

77.35(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the following conditions:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants 24 hours per day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all applicable laws and regulations relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.35(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 441—Chapter 226. Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.35(2).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Homemaker providers meeting the standards set forth in subrule 77.38(4).

77.35(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 481—Chapter 921:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent dietitians licensed pursuant to 481—Chapter 921.

77.35(13) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the following qualifications:

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

c. The financial institution shall enroll as a Medicaid provider.

77.35(14) *Independent support brokerage.* Members who select the consumer choices option may work with an independent support broker who meets the following qualifications:

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.35(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(18) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

441—77.36(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer, such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.36(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.36(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

441—77.37(249A) Hospice providers. Hospice providers that are licensed and meet the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs are eligible to participate in the Medicaid program.

441—77.38(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers are eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.38(22) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided.

77.38(1) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.38(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants 24 hours per day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all applicable laws and regulations relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.38(3) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.38(4) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

77.38(5) *Nursing care.* Nursing care providers meeting the criteria in subrule 77.35(4) are eligible to participate.

77.38(6) *Respite care.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.38(7) *Home-delivered meals providers.* Home-delivered meals providers meeting the criteria outlined in subrule 77.35(11) are eligible to participate.

77.38(8) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.38(9) *Mental health outreach providers.* Community mental health centers or other accredited behavioral health providers meeting the criteria outlined in rule 441—77.31(249A) may provide mental health outreach services.

77.38(10) *Transportation service providers.* The following providers may provide transportation services:

a. Area agencies on aging as designated in 441—Chapter 226. Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging

stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the department of transportation.

d. Supported community living providers certified pursuant to subrule 77.40(2) or 77.42(12).

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation broker.

77.38(11) *Nutritional counseling.* Providers meeting the criteria outlined in subrule 77.35(12) may provide nutritional counseling.

77.38(12) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to 441—Chapter 226.

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.38(13) *Companion services.* Senior companion programs designated by the Corporation for National and Community Service may provide companion services.

77.38(14) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.38(15) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.38(16) *Independent support brokerage.* Members who select the consumer choices option may work with an independent support broker who meets the criteria outlined in subrule 77.35(14).

77.38(17) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.38(18) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.38(19) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.38(20) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the standards outlined in 441—Chapter 90.

77.38(21) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, except for providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

77.38(22) *Assisted living on-call service.* Assisted living on-call service providers shall be assisted living programs that are certified by DIAL under 481—Chapter 69.

441—77.39(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver

Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program.

77.39(1) *Counseling providers.* Counseling providers that meet the criteria outlined in subrule 77.35(6).

77.39(2) *Home health aide providers.* Home health aide providers that meet the requirements outlined in subrule 77.35(2).

77.39(3) *Home maintenance providers.* Home maintenance providers that meet the requirements outlined in subrule 77.35(1).

77.39(4) *Nursing care providers.* Nursing care providers that meet the requirements outlined in subrule 77.35(4).

77.39(5) *Respite care providers.* Respite care providers that meet the criteria outlined in subrule 77.35(5).

77.39(6) *Home-delivered meal providers.* Home-delivered meal providers that meet the criteria outlined in subrule 77.35(11).

77.39(7) *Adult day care providers.* Adult day care providers that meet the criteria outlined in subrule 77.35(3).

77.39(8) *Attendant care providers.* Attendant care providers that meet the criteria outlined in subrule 77.35(7).

77.39(9) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.39(10) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.39(11) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.39(12) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.39(13) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.39(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers, except for providers of goods and services purchased under the consumer choices option or home-delivered meals, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

441—77.40(249A) HCBS intellectual disability waiver service providers. HCBS intellectual disability waiver services shall be rendered by providers meeting the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.40(1) *Review of providers.* Reviews of compliance with standards as indicated in this chapter and the requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, will be conducted by designated department team members.

77.40(2) *Supported community living (SCL) providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of SCL may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. Agencies meeting the criteria under subrule 77.40(2) that seek designation as an intensive residential service provider shall meet the criteria pursuant to paragraph 77.30(8)*"b"* at initial application and annually thereafter.

e. All SCL providers shall meet the following requirements:

(1) The provider shall demonstrate the outcomes and processes in rule 441—77.40(249A) for each of the members being served.

(2) Reserved.

77.40(3) *Respite care providers.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.40(4) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.25(9) are eligible to participate.

77.40(5) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.40(6) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.40(7) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.40(8) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.40(9) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.40(10) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.40(11) *Residential-based supported community living service providers.*

a. The department will only enroll public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for children with an intellectual disability or brain injury under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's intellectual disabilities and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every three years in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.

- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and member representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the member. The service provider shall distribute the policies for member appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
4. Specific service activities to be provided to achieve the objectives.
5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
6. Date of service initiation and date of individual service plan development.
7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child as listed on the Supports Intensity Scale® (SIS) assessment as amended to July 1, 2026.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child as listed on the SIS assessment as amended to July 1, 2026.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(2) The provider supplies the department with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.

2. What physical change will need to take place in the living units.

3. How children and their families will be involved in the transitioning process.

4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.42(7).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.42(8).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, annual recertification will be based on an on-site review and will be contingent upon demonstration of compliance with certification requirements.

The department will hold an exit conference with the provider to share preliminary findings of the recertification review. The department will write and send to the provider a review report within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification will be effective on the date identified on the Certificate of Approval and will terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification

review to give the provider time to establish and implement corrective actions and improvement activities.

- During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.
- Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a department review team member encounters a situation that places a member in immediate jeopardy, the department review team member will immediately notify the provider and other department review team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider will not be certified. The department will immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time, the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each department review team member will follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department will establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists that is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to subrule 70.40(1) and numbered paragraph 77.40(11)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to subrule 70.40(1) and numbered paragraph 77.40(11)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to subrule 77.40(1) and subparagraph 77.40(11)*"f"*(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services will be subject to reviews of compliance with program requirements.

77.40(12) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.40(13) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.40(14) *Prevocational service providers.* Prevocational service providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.40(15) *Day habilitation providers.* Day habilitation services may be provided by agencies meeting the qualifications outlined in subrule 77.30(7).

77.40(16) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.40(17) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.40(18) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.40(19) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.40(20) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

441—77.41(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.41(1) *Minimum composition.* At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.41(2) *Psychiatrists.* A psychiatrist on the team shall be a physician (MD or DO) who:

a. Is licensed under 481—Chapter 653;

b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; and

c. Has experience treating serious and persistent mental illness.

77.41(3) *Registered nurses.* A nurse on the team shall:

a. Be licensed as a registered nurse under 481—Chapter 617, and

b. Have experience treating persons with serious and persistent mental illness.

77.41(4) *Behavioral health service providers.* A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 481—Chapter 880, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master-level or independent-level social worker under 481—Chapter 880, and

(2) Has experience treating persons with serious and persistent mental illness.

77.41(5) *Psychologists.* A psychologist on the team shall:

a. Be licensed under 481—Chapter 880, and

b. Have experience treating persons with serious and persistent mental illness.

77.41(6) *Substance abuse treatment professionals.* A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)*"b,"* and

b. Have at least three years of experience treating substance abuse.

77.41(7) *Peer specialists.* A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer

support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.41(8) *Community support specialists.* A community support specialist on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

77.41(9) *Case managers.* A case manager on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of "qualified case managers and supervisors" in rule 441—24.1(225A).

77.41(10) *Advanced registered nurse practitioners.* An advanced registered nurse practitioner on the team shall:

a. Be licensed under 481—Chapter 621,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.41(11) *Physician assistants.* A physician assistant on the team shall:

a. Be licensed under 481—Chapter 780,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

441—77.42(249A) HCBS brain injury (BI) waiver service providers. HCBS BI waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct member service must have completed the department's brain injury training modules within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.42(10). Attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrule 77.42(1) and be evaluated according to subrules 77.42(7) through 77.42(9) and meet the requirements of subrules 77.42(2) through 77.42(6). Respite providers shall also meet the standards outlined in subrule 77.42(1).

The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS BI waiver service providers.

77.42(1) *Outcome-based standards.* The provider shall have organizational and rights and dignity outcome-based standards pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(2) *The right to appeal.* Members and their legal representatives have the right to appeal the provider's application of policies or procedures or any staff or contractual person's action that affects the member. The provider shall distribute the policies for member appeals and procedures to members.

77.42(3) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers a prescription or an over-the-counter medication, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with rule 481—63.16(135C).

77.42(4) *Research.* If the provider conducts research involving members, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that members' rights are protected.

77.42(5) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS BI waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(6) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.42(7) *Certification process.* The department will conduct reviews of compliance with standards for initial certification and recertification. Certification carries no assurance that the approved provider will receive funding.

The department may request any information from the prospective service provider that the department considers pertinent to arriving at a certification decision.

77.42(8) *Initial certification.* The department will review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department will make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The department's decision on the provider's initial certification will be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification will be offered technical assistance.

77.42(9) *Period of certification.* Provider certification will become effective on the date identified on the certificate of approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification will be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission, CARF, the Council on Quality and Leadership in Supports for People with Disabilities (The Council),

or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with members and significant people in the member's life to determine whether or not the individual value-based outcomes set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, and corresponding processes are present for the member. Respite services are required to meet certain outcome standards and participate in satisfaction surveys.

(1) Once the outcomes and processes have been determined for all the members in the sample, a department review team then determines which of the outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the members interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the members interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the member, length of certification will be based more heavily on whether or not the processes are in place to help members obtain desired outcomes.

(2) An exit conference will be held with the organization to share preliminary findings of the certification review. The department will write and send a review report to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

(3) Provider certification will become effective on the date identified on the Certificate of Approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period will be granted to the provider to establish and implement corrective actions and improvement activities. During this time period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days will not be renewed or extended and will require a full on-site follow-up review to be completed. The provider will be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a department team member encounters a situation that places a member in immediate jeopardy, the department team member will immediately notify the

provider and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification will not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney-in-fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time, the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each department team member will be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision that is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department will establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.42(10)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.42(10)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.42(10)*"f."*

(4) There are instances of noncompliance with the standards that were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.42(10) *Departmental reviews.* The department will conduct reviews of compliance with standards as indicated in this chapter. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, members, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews will be conducted annually with additional reviews conducted at the department's discretion.

b. Following a departmental review, the department will submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The provider shall submit the corrective action plan to the department and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.42(10)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.42(11) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS BI waiver program provided the case management provider organizations meet the standards in 441—Chapter 24 and the case management provider organizations are the department, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.42(12) *Supported community living providers.*

a. The department will certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, and 114 through 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. Providers of service may employ or contract individuals meeting the definition of host home to provide supported community living services. These individuals must meet the criteria in the HCBS Waiver Manual as amended to July 1, 2026. A host home is a community-based family home setting whose owner or renter provides HCBS SCL or HCBS home-based habilitation (HBH) services to no more than two unrelated individuals who reside with the owner or renter in their primary residence and who is approved to provide those services as an independent contractor of a community-based SCL or HBH service agency.

e. The department will approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the department in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.42(13) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

77.42(14) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.30(10) are eligible to participate.

77.42(15) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.42(16) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.42(17) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.42(18) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program that provide specialized medical equipment as described in 441—subrule 78.43(8).

77.42(19) *Adult day care providers.* Adult day care providers shall be agencies that meet the criteria outlined in subrule 77.35(3).

77.42(20) *Family training providers.* Family training providers shall be one of the following:

a. Providers certified under the community mental health center standards set forth in 441—Chapter 24 and that employ staff to provide family training who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs and that employ staff who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards set forth in 441—Chapter 24 and that employ staff to provide family training who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

e. Agencies certified as HCBS BI waiver service providers pursuant to rule 441—77.42(249A) that employ staff to provide family training who meet the definition of a "qualified brain injury professional" as set forth in rule 441—83.81(249A).

f. Agencies that are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

77.42(21) *Prevocational habilitation.* Prevocational habilitation services providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.42(22) *Positive behavioral support and consultation providers.* Positive behavioral support and consultation providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements:

a. Behavior assessment and development of an appropriate intervention plan with periodic reassessment of the appropriate intervention plan, and training of staff who shall implement the appropriate intervention plan must be done by a "qualified brain injury professional" as defined in rule 441—83.81(249A). Formal assessment of the members' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a "qualified brain injury professional" as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

(2) Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under Medicare for hospice programs.

(3) Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

(4) Home health aide providers meeting the standards outlined in subrule 77.35(2). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) HCBS BI waiver service providers certified pursuant to rule 441—77.42(249A).

(6) Agencies that are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

(7) Individuals who meet the definition of "qualified brain injury professional" as defined in rule 441—83.81(249A).

77.42(23) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.42(24) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.42(25) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.42(26) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.42(27) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.42(28) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.42(29) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

441—77.43(249A) HCBS physical disability waiver service providers. HCBS physical disability waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS physical disability waiver service providers.

77.43(1) *Enrollment process.* The department will conduct reviews of compliance with standards for initial enrollment. Enrollment carries no assurance that the approved provider will receive funding and may occur at any time. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.43(2) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.43(3) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.43(4) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.43(5) *Specialized medical equipment providers.* Specialized medical equipment providers meeting the criteria outlined in subrule 77.42(18) are eligible to participate.

77.43(6) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.43(7) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.43(8) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.35(14).

77.43(9) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.35(15).

77.43(10) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.35(16).

77.43(11) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in subrule 77.35(17).

77.43(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

441—77.44(249A) Public health agencies. A public health agency is eligible to participate in the medical assistance program when the public health agency serves as a public health entity within a local board of health jurisdiction pursuant to rule 641—77.3(137).

441—77.45(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA) as amended to July 1, 2026; and
2. Meets the following additional requirements.

77.45(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Licensed by the board of educational examiners as a mental health professional pursuant to rule 282—16.9(256);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapter 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.31(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to rule 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.45(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP), including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.24(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the IFSP.

441—77.46(249A) Local education agency (LEA) services providers. School districts accredited by the department of education pursuant to 281—Chapter 12 and Iowa educational services for the blind and the Iowa school for the deaf, both of which are governed by the department of education pursuant to Iowa Code section 256.95, are eligible to participate in the medical assistance program as providers of LEA services under rule 441—78.50(249A) if the following conditions are met.

77.46(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the board of nursing as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.13(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.46(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII.

441—77.47(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638 as amended to July 1, 2026) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 U.S.C. 1603 as amended to July 1, 2026, is eligible to participate in the medical assistance program if the following conditions are met.

77.47(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.47(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

441—77.48(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.48(1) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards in subrules 77.48(2) through 77.48(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.48(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards.

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the member or the parent or stepparent of the member.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the outcome-based standards for the rights and dignity of children with serious emotional disturbance as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review will include interviews with the member and the member's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action will be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action will be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers, except for providers of environmental modifications and adaptive devices, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.48(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS intellectual disability or BI waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.48(3) *Family and community support services providers.*

a. Qualified providers. The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under rule 441—77.13(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. As a condition of providing family and community support services under the children's mental health waiver, the agency shall meet the staff training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized "crisis intervention plan" as defined in rule 441—24.1(225A) that is developed by each member's interdisciplinary team as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.48(4) *In-home family therapy providers.*

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 481—Chapter 880 or possessing an equivalent license in another state.

b. Staff training. As a condition of providing in-home family therapy under the children's mental health waiver, the agency shall meet the training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized "crisis intervention plan" as defined in rule 441—24.1(225A) that is developed by each member's interdisciplinary team.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.48(5) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

441—77.49(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

441—77.50(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

441—77.51(249A) Community-based neurobehavioral rehabilitation services.

77.51(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

77.51(2) *Eligible providers.* The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.51(3) *Provider standards.* All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a CBIST through the ACBIS or a CBIS under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator's absence.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;
2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;
3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or
4. Be a CBIS certified through the ACBIS or have other nationally recognized brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum, the training includes the following:

(1) Completion of the department-approved brain injury training modules.
(2) Member rights.
(3) Confidentiality and privacy.
(4) Dependent adult and child abuse prevention and mandatory reporter training.
(5) Individualized rehabilitation treatment plans.
(6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.51(3)*"a"*(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBIS certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

f. The organization shall have in place an outcome management system that measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.
(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.
(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.30(3) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement outcome-based standards for rights and dignity.

441—77.52(249A) Qualified Medicare beneficiary (QMB) providers. Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider. A QMB-eligible member must meet the criteria outlined in 441—subrule 75.1(29).

77.52(1) *Reimbursement.* A QMB provider may only bill the department for the QMB-eligible member's Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

77.52(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicare cost sharing" means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

441—77.53(249A) Health insurance premium payment (HIPP) providers. Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket, cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance paid for through the HIPP program. HIPP-eligible members must meet the criteria outlined in rule 441—75.21(249A).

441—77.54(249A) Crisis response services.

77.54(1) *Definitions.* The terms used in this rule shall have the same meaning as those set out in 441—Chapter 24.

77.54(2) *Eligible providers.* Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24 are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

77.54(3) *Provider standards.* All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24.

441—77.55(249A) Subacute mental health services.

77.55(1) *Definitions.* The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

77.55(2) *Subacute mental health services.* Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

77.55(3) *Eligible provider.* Subacute mental health care facilities that are licensed by DIAL in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

77.55(4) *Provider standards.* All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

These rules are intended to implement Iowa Code section 249A.4.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 78
"Amount, Duration and Scope of Medical and Remedial Services"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines parameters for provision and payment for services under Iowa Medicaid. The proposed chapter provides guidance to participating providers and members about which services are covered, are not covered, and require prior authorization.

This proposed rulemaking is being undertaken as a result of Executive Order 10. As a result of its review, the Department eliminated some restrictive and outdated terms, referred items back to the Iowa Code or to program manuals, made technical corrections, deleted references to programs that are sunsetting, and updated terminology.

In addition, the Department updated the home-based habilitation benefit in certain Medicaid waivers to reflect changes made by 2025 Iowa Acts, Senate File 474, section 40, which lowers the age at which individuals may receive home-based habilitation services under those waivers from 17 years of age to 16 years of age.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Health care providers that participate with Iowa Medicaid, as well as Iowa Medicaid members, will benefit from the guidance provided in this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Because of the Red Tape Review conducted pursuant to Executive Order 10, the word count of this chapter has been reduced by 7,793 words and restrictive terms have been reduced by 267 words.

- **Qualitative description of impact:**

Iowa Medicaid providers and members will benefit from updated terminology and references in the proposed chapter.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to enforce this chapter.

- **Anticipated effect on State revenues:**

This proposed rulemaking has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Administrative rules are required and necessary to help ensure that Iowa Medicaid members can receive timely and quality health care services in the most effective and efficient manner possible.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 78 and adopt the following **new** chapter in lieu thereof:

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician, including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment will be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant (PA), or advanced registered nurse practitioner (ARNP)) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the department.

b. Treatment of certain foot conditions as specified in paragraphs 78.15(3)*"a"* and *"b."*

c. Acupuncture treatments.

d. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program will be utilized in determining when a given procedure is unproven or experimental in nature.

e. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by Iowa Medicaid or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admission to the hospital. Approval will be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" will be published by the department in the provider manuals for hospitals and physicians as amended to July 1, 2026. The "Outpatient/Same Day Surgery List" will be developed by Iowa Medicaid and will include procedures that can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. Iowa Medicaid may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

f. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308 and 155A.27. For the purposes of the medical assistance program, prescriptions for medical supplies are required and will be subject to the same provisions.

d. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug are not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury.

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the VFC program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form but that does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders. This subparagraph is intended to implement Iowa Code section 249A.14 as enacted by 2025 Iowa Acts, House File 1049, section 14.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that are not covered under the program. This list is for example purposes only and is not considered all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties unless there is evidence of accidental injury occurring within the past six months that resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage will not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 441—78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment will be made for the services of a private duty nurse.

78.1(8) Payment for mileage will be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit, the allowance will be based on a follow-up home visit. When more than one patient is seen in a single visit, payment will be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care that are performed by a nurse practitioner or PA as specified in 42 CFR 483.30(f). On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Reserved.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision.

(1) Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

(2) Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

(3) ARNPs certified under board of nursing rules in 481—Chapter 621 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. ARNPs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

(4) A PA licensed under board of PAs' professional licensure rules in 481—Chapters 780 through 784 is exempt from the direct personal supervision requirement, except as expressly required by Iowa Code chapter 148C or 481—Chapters 780 through 784. A physician shall be accessible at all times for consultation with a PA unless the PA is providing emergency medical services pursuant to 481—subrule 781.1(3). PAs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A) or required by rules in 481—Chapters 780 through 784. PAs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the

physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care will be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and that is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) A department consent form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the department form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent, except in the case of premature delivery or emergency abdominal surgery that occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs 78.1(16)*"b"* through *"f"* shall be effectively presented to a blind, deaf, hard-of-hearing, or otherwise disabled individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by all parties required by the form.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth,

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment of having been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing,

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy, and the physician has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when a Certification Regarding Abortion form is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant individual's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. The Certification Regarding Abortion form shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. The Certification Regarding Abortion form shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids shall be the same as described in rule 441—78.6(249A).

78.1(19) Preprocedure review by Iowa Medicaid will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures that have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by Iowa Medicaid will be granted only if the procedures are determined to be medically necessary based on

the condition of the patient and the criteria established by Iowa Medicaid. If not so approved by Iowa Medicaid, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from Iowa Medicaid.

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by Iowa Medicaid. Covered liver transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by Iowa Medicaid. Covered heart transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by Iowa Medicaid. Covered transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph 78.1(2)*"a"*(5).

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

3. The pancreas transplants listed under this subparagraph require preprocedure review by Iowa Medicaid.

4. Covered transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

5. Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph 78.1(20)*"a."*

78.1(21) Utilization review. Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist.

78.1(22) Risk assessment. Risk assessment, using the Medicaid Prenatal Risk Assessment form, will be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral will be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement will be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) Reserved.

78.1(24) Topical fluoride varnish. Payment will be made for application of an FDA-approved topical fluoride varnish, as defined by the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment will be available only for application of topical fluoride varnish, which will be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening will not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

78.1(25) Prior authorization for medication-assisted treatment will be governed pursuant to subrule 78.28(2).

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) as amended to July 1, 2026, subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(39).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy. All prescriptions or drug orders shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990 as amended to July 1, 2026).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed department Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment will be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act as amended to July 1, 2026.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Reserved.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 as amended to July 1, 2026, and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations as amended to July 1, 2026 (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration (FDA).

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the FDA but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4) as amended to July 1, 2026.

78.2(5) *Nonprescription drugs.*

a. Nonprescription or over-the-counter (OTC) refers to a drug that may be lawfully sold without a prescription; however, Iowa Medicaid requires a prescription for covered OTC drugs. These drugs are subject to prior authorization requirements as specified in the preferred drug list (PDL) published by the department pursuant to Iowa Code section 249A.20A. The drugs are identified on the nonprescription (OTC) prescribed list by therapeutic category located on the PDL website (www.iowamedicaidpdl.com) under the PDL/PA tab.

b. Nonprescription drugs for use in a nursing facility, psychiatric medical institution for children (PMIC), or intermediate care facility for persons with an intellectual disability (ICF/ID) will be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID, with the exception of OTC insulin and pseudoephedrine.

78.2(6) *Quantity prescribed.*

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and
- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990) as amended to July 1, 2026, a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation can be found in rules of the Iowa board of pharmacy.

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by Iowa Medicaid. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the

services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. The criteria are available from Iowa Medicaid or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity require prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided to inpatients subject to the same provisions specified in subrule 78.2(1) and subparagraphs 78.2(4)*"b"*(1) through *"b"*(10), except for *"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided to outpatients subject to the same provisions specified in subrules 78.2(1) through 78.2(4), except for subparagraph 78.2(4)*"b"*(7). The basis of payment for drugs provided to outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the VFC program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital will be made to those hospitals certified by the department of inspections, appeals, and licensing as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment will be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Payment will be made for medically necessary inpatient acute psychiatric intensive care services that meet the criteria in this subrule, pursuant to 441—paragraph 79.1(5)*"i."* This inpatient rate is only applicable to individuals 18 to 64 years of age. All inpatient acute psychiatric intensive care services require prior authorization.

a. "Acute psychiatric intensive care" is defined as care provided for a condition with rapid onset that is accompanied by severe symptoms and is generally of brief duration, requiring emergency treatment and critical care.

b. To meet the need for acute psychiatric intensive care, the patient must:

(1) Have a serious and persistent mental illness as defined in 441—subrule 77.25(1);

(2) Have a current, severe, imminent risk of serious harm to self or others; and

(3) Display additional complexity of need related to:

1. Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries; or

2. A history of violence or current aggression that is secondary to mental illness; or

3. A request for patient transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms; or

4. Lack of responsiveness to typical interventions or a condition that is treatment refractory; or

5. Disorganized psychotic state or manic thought process that impairs the ability to function or risks the safety of the patient or others; or

6. Behavior that causes disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); or

7. High elopement risk; or

8. Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the patient and others around the patient safe.

c. The individual must have a documented need for acute intensive care requiring increased or specialized staffing, equipment, or facilities, based on two or more of the following:

(1) Fall precaution protocol in place;

(2) Restraints or seclusion room requirements;

(3) Requiring assistance with activities of daily living;

(4) Requirements for complex nursing care;

(5) Acutely impaired cognitive functioning from baseline;

(6) Documentation of interventions to address acute complex mental illness and comorbidities;

(7) Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure;

(8) Elopement risk precaution protocol in place.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified. The team should consist of:

1. A surgeon director.
2. A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

1. Anesthesiology.
2. Cardiology.
3. Dialysis.
4. Gastroenterology.
5. Hepatology.
6. Immunology.
7. Infectious diseases.
8. Nephrology.
9. Neurology.
10. Pathology.
11. Pediatrics.
12. Psychiatry.
13. Pulmonary medicine.
14. Radiology.
15. Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include persons with expertise in the following areas available at the transplant center:

1. Anesthesiology.
2. Blood bank services.
3. Cardiology.
4. Cardiovascular surgery.
5. Dialysis.
6. Dietary services.
7. Gastroenterology.
8. Infection control.
9. Laboratory services (pathology, microbiology, immunology, tissue typing, andimmunosuppressive drug monitoring).
10. Legal counsel familiar with transplantation laws and regulations.
11. Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.
12. Respiratory therapy.
13. Pharmaceutical services.
14. Physical therapy.
15. Psychiatry.
16. Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI) as amended to July 1, 2026. As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year. For approval of an extrarenal organ transplant program it is highly desirable that the institution:

1. Has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or
2. Has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network. Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

1. Risk and benefit.
2. Morbidity and mortality.
3. Long-term survival.
4. Quality of life.
5. Recipient demographic information.

These data should be compiled and maintained at the transplant center monthly. The transplant center will submit the above data to the United Network for Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research. Ongoing research regarding the transplanted organs is required. The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program. The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient. The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program. The transplant center will provide information to members

of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process. The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to Iowa Medicaid. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to Iowa Medicaid.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

(1) There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

(2) Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes that would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists. Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given. The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by Iowa Medicaid to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f,"* with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective:

a. As of the date of notice by Iowa Medicaid that the lower level of care is required, or

b. For the days Iowa Medicaid determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by Iowa Medicaid to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 81.5(16)*"f,"* with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective:

a. As of the date of notice by Iowa Medicaid that the lower level of care is required, or

b. For the days Iowa Medicaid determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by Iowa Medicaid. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the Iowa Medicaid medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by Iowa Medicaid pursuant to 441—Chapter 7.

78.3(16) Skilled nursing care in "swing beds."

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections, appeals, and licensing and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)*"a."*

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member's LOC needs, using a department Swing Bed Certification form.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a

Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Reserved.

78.3(18) Preprocedure review by Iowa Medicaid is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from Iowa Medicaid.

441—78.4(249A) Dental services. Payment is authorized only for medically necessary dental and oral surgery services provided by a dentist to the extent these services are permitted to be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy.

78.4(1) *Covered services.* Covered dental services include preventive, diagnostic, restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, orthodontic, and adjustive general procedures as defined in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(2) *Prior authorization.* Certain dental services require prior authorization. Covered dental service categories requiring prior approval are defined and outlined in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(3) *Service setting.* When dental services cannot be safely performed in a dental office, they may be provided in a hospital or ambulatory surgical center and reimbursed in accordance with rule 441—78.26(249A).

78.4(4) *Compliance.* Payment requires compliance with Iowa Medicaid policies, clinical criteria, and documentation requirements as specified in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(5) *Annual benefit maximum.*

a. Members 21 years of age or older have an annual benefit maximum of $1,000 per state fiscal year for coverage of dental services set forth in this rule. Payment for services exceeding the $1,000 annual benefit maximum is the responsibility of the member.

b. The following services do not count toward the annual benefit maximum:

(1) Preventive services;

(2) Diagnostic services;

(3) Fabrication of removable dentures and related services;

(4) Anesthesia when provided in conjunction with oral surgery codes approved for payment; or

(5) Emergency services.

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered. Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)*"c."* Payment will be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from Iowa Medicaid. Payment will not be made for writing prescriptions.

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services.* Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage will be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage will be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Reserved.

h. Repairs or replacement of frames, lenses or component parts. Payment will be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment will be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment will be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.

(2) Up to eight gas permeable contact lenses are allowed every 12 months for children one through three years of age.

(3) Up to six gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) *Ophthalmic materials.* Ophthalmic materials that are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance as amended to July 1, 2026.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval will be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process will be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles,

or reverse Galilean telescope systems. Payment will be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint will be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms will be granted for members whose vision cannot be adequately corrected with other covered prisms.

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies are the same as described in rule 441—78.6(249A).

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

b. The neuromusculoskeletal conditions listed on the department's website indicate whether the conditions require short-, moderate-, or long-term CMT. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment will be made for subsequent X-rays, absent a new condition, consistent with paragraph 78.8(3)*"c."* No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly

authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors will be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays will be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays will be further limited to one per condition, consistent with the provisions of paragraph 78.8(3)*"a."* A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph 78.8(3)*"a."* A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered will be payable to the X-ray provider, consistent with the provisions in this paragraph.

441—78.9(249A) Home health agencies. Payment will be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or PA in a plan of home health care provided by a Medicare-certified home health agency.

1. The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

2. The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency will only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at paragraph 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

3. Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

4. Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) through 78.9(10).

5. Payment will be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

6. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy.

7. Payment may be made for restorative and maintenance home health agency services.

8. Payment may be made for teaching, training, and counseling in the provision of health care services.

9. Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

10. The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

11. Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or PA, evidenced by the physician's, nurse practitioner's, clinical nurse specialist's, or PA's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a PA and the Medicaid member no more than 90 days before or 30 days after the start of service. The plan of care

shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of member in response to treatment.
g. Medical supplies to be furnished.
h. Member's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or PA.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 60 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's, nurse practitioner's, clinical nurse specialist's, or PA's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or PA before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment will be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services are defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end will be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or PA's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections will be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a PA and included in the plan of care. Other daily skilled nursing visits that are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and will be denied.

a. Skilled nursing services will be evaluated based on the complexity of the service and the condition of the patient.

b. Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment will be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1) *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment will be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment will be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment will be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or PA. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or PA and included in a plan of care will be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

(1) Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

(2) Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

(3) Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase

the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services that are not related to patient care are not a covered service if personal care is not rendered during the visit.

(4) For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) Reserved.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children is to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom that verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under will be approved if determined to be medically necessary. Payment will be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services that are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals.

1. Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule will be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

2. Private duty nursing or personal care services do not include:

- Respite care, which is a temporary intermission or period of rest for the caregiver.
- Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.

- Services provided to other persons in the member's household.
- Services requiring prior authorization that are provided without regard to the prior authorization process.
- Transportation services.
- Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services will be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

78.9(11) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by Iowa Medicaid.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), PA's, or ARNP's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, PA's, or ARNP's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using an Outpatient Prior Authorization Request form. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item that meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator, with approved medical necessity.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase will be made by Iowa Medicaid and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) for prior authorization requirements.

78.10(2) *Durable medical equipment.* DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. DME in a hospital, nursing facility, or ICF/ID is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an ICF/ID when all of the following requirements and conditions have been met:

1. Medical documentation or a reasonable facsimile is completed by a physician, PA, or ARNP and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment will be based on the least costly method of oxygen delivery.

5. Oxygen prescribed "PRN" or "as necessary" is not payable.

6. Medicaid payment will be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections, appeals, and licensing requirements in 481—Chapter 58.

(2) Speech generating devices with approved medical necessity.

(3) Wheelchairs for members in an ICF/ID.

b. The types of DME covered through the Medicaid program include but are not limited to:

Automated medication dispenser.

Bathtub/shower chair, bench. See subrule 78.10(5) for prior authorization requirements.

Commode, shower commode chair. See subrule 78.10(5) for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See subrule 78.10(5) for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See subrule 78.10(5) for prior authorization requirements.

Insulin infusion pump. See subrule 78.10(5) for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See subrule 78.10(5) for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in paragraphs 78.10(2)*"a"* and *"c."*

Patient lift. See subrule 78.10(5) for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See subrule 78.10(5) for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, PA, or ARNP shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, PA, or ARNP. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, medical documentation, or a reasonable facsimile completed by a physician, PA, or ARNP shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, PA, or ARNP must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, PA, or ARNP of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems will be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and

5. Anti-rollback devices.

(3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:

1. Lap belt or safety belt;
2. Battery charger, single mode;
3. Complete set of tires/wheels and casters, any type;
4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches;
- EXCEPTION: For extra heavy duty, there is no separate billing;

9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches;
- EXCEPTION: For extra heavy duty, there is no separate billing;

10. Non-expandable controller or standard proportional joystick (integrated or remote); and
11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:

1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items are payable with a prior authorization, in accordance with 42 CFR 414.224 as amended to July 1, 2026.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), PA, or ARNP within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include but are not limited to:

(1) Artificial eyes.
(2) Artificial limbs.

(3) Enteral delivery supplies and products. See subrule 78.10(5) for prior authorization requirements.

(4) Hearing aids. See rule 441—78.14(249A).

(5) Orthotic devices. See paragraph 78.10(3)*"c"* for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost.

c. Cranial orthotic device. Payment will be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and meets minimum medical necessity requirements.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See subrule 78.10(5) for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See subrule 78.10(5) for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an ICF/ID when prescribed by the physician, PA, or ARNP:

(1) Catheter (indwelling Foley).

(2) Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

(3) Disposable catheterization trays or sets (sterile).

(4) Disposable irrigation trays or sets (sterile).

(5) Disposable saline enemas (e.g., sodium phosphate type).

(6) Ostomy appliances and supplies.

(7) Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for some medical equipment and supplies. Refer to the department's website for a list of items that require a prior authorization.

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home, to a nursing facility, or to a mental health access center. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) Iowa Medicaid will determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or is in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements will not be applicable. Approval for transfer will be made by the department prior to the transfer. When such a transfer is made, the following rate schedule will apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment will be made only to one ambulance company. When a paramedic

from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a PA, an ARNP, a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

"Managed care organization" 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" as defined in Iowa Code section 514B.1.

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as amended to July 1, 2026, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) *Covered services.*

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered as behavioral health interventions. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered as behavioral health interventions.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.13(249A); and

(5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by subparagraph 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) *Covered services.* Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

(1) Mileage reimbursement to the member, if the member is the driver.

(2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.

(3) Taxi service.

(4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.

(5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) *Exclusions.* Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to DME providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) *Conditions and limitations on covered services.* Nonemergency medical transportation services are subject to the following limitations and conditions:

a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

(1) Whether the member owns a vehicle;

(2) Whether a member-owned vehicle is in working mechanical order and is licensed;

(3) Whether the member has a valid driver's license and auto insurance;

(4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and

(5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

(1) The transportation being provided spans the entire meal period;

(2) The one-way distance to or from the medical appointment is more than 50 miles;

(3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and

(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) *Grievance procedure.* The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person."

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)*"b,"* the grievance process shall end with binding arbitration, with a designee of Iowa Medicaid as arbitrator.

441—78.14(249A) Hearing aids. Payment will be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department will cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department will make payment for travel to the member's place of residence or other suitable location. The department will make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department will pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.14(249A). The department will pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids will be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department will make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries will be at the current audiologist's fee schedule.

c. Payment for repairs will be made to the dealer for repairs made by the dealer. Payment for in-house repairs will be made at the current fee schedule. Payment will also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs will be at the amount shown on the manufacturer's invoice. Payment will be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, an Examiner Report of Need for a Hearing Aid form shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old will require prior approval except when the member is under 21 years of age. The department will approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid.

(2) Payment for a hearing aid costing more than $650 will require prior approval. The department will approve payment for either of the following purposes:

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

441—78.15(249A) Orthopedic shoes. Payment will be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule as amended to July 1, 2026, or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a PA, or an ARNP that includes all of the following:

a. The date.
b. The patient's diagnosis.
c. The reason orthopedic shoes are needed.
d. The probable duration of need.
e. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the International Classification of Diseases (ICD) as amended to July 1, 2026. A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.

(2) Pain.

(3) Tissue breakdown or a high probability of tissue breakdown.

(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology as amended to July 1, 2026, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed that shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department or its designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225A) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* through *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—24.1(225A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—24.1(225A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services, including individual, group, and family therapy.

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals

with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the Diagnostic and Statistical Manual of Mental Disorders as amended to July 1, 2026. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment that reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals that are general statements of member outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered on the "National Register of Health Service Providers in Psychology" as amended to July 1, 2026. Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference

with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

(1) The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

(2) Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(3) Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

(4) Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225A) can receive day treatment services under this subrule or subrule 78.16(6).

441—78.17(249A) Physical therapists. Payment will be approved when the services provided relate directly to an active written treatment plan; follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA after any needed consultation with the qualified physical therapist; are reasonable and necessary to the treatment of the patient's illness or injury; and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"b."*

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in rule 441—84.1(249A) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the VFC program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Seven screenings in the first year of life.

(2) Four screenings between the ages of 13 months and 30 months.

(3) One screening per year at ages three, four, five, and six.

(4) One screening per year at ages 7 through 21.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Reserved.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment will be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an ICF/ID, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections, appeals, and licensing are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will Iowa Medicaid or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an ICF/ID. Physical, occupational, and speech therapy services for residents of the nursing facility, ICF/ID, or hospital are the responsibility of the nursing facility, ICF/ID, or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to subparagraphs 78.19(1)*"b"*(7) and *"b"*(8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length unless an untimed or encounter billing code is used.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to subparagraphs 78.19(1)*"b"*(7) and *"b"*(8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to subparagraph 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist.

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

1. Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

2. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

3. After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

4. When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals will be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

1. When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

2. At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

3. Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See numbered paragraph "4" below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

4. The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

- There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)
- Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
- Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.
- If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential

setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

- For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.
- Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.
- Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.
- Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions that have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist, and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in subparagraphs 78.19(1)*"b"*(7), *"b"*(8), and *"b"*(16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of subparagraph 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient that require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services that are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis that will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities that are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in subparagraphs 78.19(1)*"b"*(7), *"b"*(8), and *"b"*(16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then the fifth paragraph under subparagraph 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to subparagraph 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).
(2) Prior teaching, training, or counseling provided.
(3) The medical necessity of the rendered services.
(4) The identification of specific services and goals.
(5) The date of the start of the services.
(6) The frequency of the services.
(7) Progress in response to the services.
(8) The estimated length of time the services are needed.

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program. Payment will be made for sterilization in accordance with subrule 78.1(16).

78.21(1) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.21(2) *Risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.21(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with subrule 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the VFC program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, that provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with subrule 78.1(16).

78.23(2) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.23(3) *Risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.23(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist will be made on a fee for service basis.

a. Payment will be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in subrule 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service that does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using a Medicaid Prenatal Risk Assessment form shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).)

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a PA, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and PAs performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Reserved.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which will include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board in 481—Chapter 576.

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented on the Medicaid Prenatal Risk Assessment form. An appropriately trained physician or ARNP must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Reserved.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures will be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure will be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by Iowa Medicaid is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from Iowa Medicaid.

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through Iowa Medicaid. Payment will only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Benefits education" means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

"Career exploration," also referred to as "career planning," means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

"Career plan" means a written plan documenting the member's stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state's minimum wage.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Certified employment specialist" or *"CES"* means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

"Child and Adolescent Level of Care Utilization System" or *"CALOCUS"* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service and intensive residential habilitation services for individuals aged 16 to 18.

"Comprehensive service plan" means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Customized employment" means an approach to supported employment that individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer.

Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Individual employment" means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Individual placement and support" or *"IPS"* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat as amended to July 1, 2026, and as measured by its employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

"Integrated community employment" means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and that presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation, home-based habilitation, or HCBS intellectual disability waiver supported community living and meet additional criteria specified in rule 441—77.30(249A) and the provider manual as amended to July 1, 2026.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"IoWANS" means the department's Institutional and Waiver Authorization and Narrative System.

"Level of Care Utilization System" or *"LOCUS"* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation and intensive residential services for individuals aged 19 and older.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

"Severe and persistent mental illness" or *"SPMI"* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic

mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational, or vocational roles.

"Supported employment" means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

"Supported self-employment" includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

"Sustained employment" means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria.

a. LOCUS/CALOCUS actual disposition. The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

b. Risk factors. The member meets the risk-based criteria as defined in the HCBS habilitation manual.

c. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the needs-based criteria as defined in the HCBS habilitation manual on a continuing or intermittent basis for at least 12 months.

d. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

e. Needs assessment. The department-approved assessment tool has been completed, and Iowa Medicaid has determined that the member is in need of home- and community-based habilitation services.

f. Designated case manager. The designated case manager shall:

(1) Arrange for the completion of the needs-based assessment before services begin, and annually thereafter, and more frequently if significant observable changes occur in the member's situation, condition, or circumstances.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4) and 441—paragraph 90.4(1) *"b"* before services begin and annually thereafter, and when there is a significant observable change in the member's situation, condition, or circumstances.

g. Plan for service. The department or the member's MCO has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated by Iowa Medicaid or the member's MCO will be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1)*"b."* A service plan may change when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member's needs-based assessment, actual disposition, the composite score, and each individual domain score for each of the six assessed domains.

(3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The member or case manager shall apply for habilitation services on behalf of a member by contacting Iowa Medicaid. The department will issue a notice of decision to the applicant in accordance with 441—Chapter 16 when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis. The comprehensive service plan will meet the criteria described in the HCBS habilitation manual.

b. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

c. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as detailed in the HCBS habilitation manual.

d. Plan approval. Services shall be entered into IoWANS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through IoWANS will be considered approved by the department. Services must be authorized in IoWANS as specified in paragraph 78.27(2)*"g."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions. Payment will not be made for case management provided to a member who is eligible for targeted case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities to address daily living needs;

(3) Assistance with symptom management and participation in mental health treatment;

(4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;

(5) Assistance with accessing and participating in substance use disorder treatment and services;

(6) Assistance with medication administration and medication management;

(7) Assistance with understanding communication whether verbal or written;

(8) Community inclusion and active participation in the community;

(9) Transportation;

(10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;

(11) Social and leisure skill development;

(12) Personal care; and

(13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member's home and community.

(1) A member may live in the member's own home, within the home of the member's family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.30(5).

(2) A member living with the member's family or legal representative is not subject to the criteria in 441—paragraphs 77.30(7)*"d"* and *"e."*

(3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member's most current assessment of need according to the criteria detailed in the HCBS habilitation manual.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

(3) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.30(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Individuals under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

(4) The member's parent or guardian has consented to home-based habilitation services.

(5) The member is able to pay room and board costs (funding sources may include but are not limited to supplemental security income, child support, adoptions subsidy, or private funds).

(6) Youth under the age of 16 needing daily home-based habilitation outside the family home must receive services in a licensed or certified residential-based supported community living setting.

e. Exclusions. Home-based habilitation payment will not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an ICF/ID.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

(1) Identifying the member's interests, preferences, skills, strengths and contributions,

(2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,

(3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,

(4) Developing skills and competencies necessary to pursue competitive integrated employment,

(5) Participating in community activities related to hobbies, leisure, personal health, and wellness,

(6) Participating in community activities related to cultural, civic, and religious interests,

(7) Participating in adult learning opportunities,

(8) Participating in volunteer opportunities,

(9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,

(10) Assistance with behavior management and self-regulation,

(11) Use of transportation and other community resources,

(12) Assistance with developing and maintaining natural relationships in the community,

(13) Assistance with identifying and using natural supports,

(14) Assistance with accessing financial literacy and benefits education,

(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

e. Duration. Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment will not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) *Prevocational service habilitation.* "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,
2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services that lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)*"a"*(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)*"a"*(1). This time limit can be extended as stated in numbered paragraphs 78.27(9)*"e"*(1)"1" through "6." If the criteria in numbered paragraphs 78.27(9)*"e"*(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) *Supported employment services.*

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a

work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)*"a"*(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is

that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, which allows the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)*"b"*(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of

workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

d. Individual placement and support (IPS).

(1) IPS shall include the following activities, which shall be described and documented in the member's employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.
2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.
3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.
4. Rapid job search and systematic job development. Community and employment supports (CESs) help members seek jobs directly and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.
5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.
6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.
2. Outcome #2: First day of successful job placement.
3. Outcome #3: 45 days successful job retention.
4. Outcome #4: 90 days successful job retention.

e. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

f. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed the cost limitations published on the Iowa Medicaid fee schedule webpage.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

g. Exclusions. Supported employment services payments will not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. Denial. Services will be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision pursuant to 441—Chapter 16 to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision will be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action pursuant to 441—Chapter 16 and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility or of the actual disposition score by sending a letter requesting a review to Iowa Medicaid at the department's address. If dissatisfied with that decision, the member may file an appeal with the department.

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, PA, or ARNP that are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Reserved.

c. Enteral products and enteral delivery pumps and supplies. Payment will be approved pursuant to the criteria in subrule 78.10(5).

d. Reserved.

e. Speech generating device. Payment will be approved pursuant to the criteria in subrule 78.10(5).

f. Preprocedure review by Iowa Medicaid will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures that have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by Iowa Medicaid will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department. If not approved by Iowa Medicaid, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from Iowa Medicaid.

g. Enclosed beds. Payment will be approved pursuant to the criteria in subrule 78.10(5).

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria.

i. Oral nutritional products. Payment will be approved pursuant to the criteria in subrule 78.10(5).

j. Vest airway clearance system. Payment will be approved pursuant to the criteria in subrule 78.10(5).

k. DME rebate agreements. Payment will be approved pursuant to the criteria in subrule 78.10(5).

l. Reimbursement over the established Medicaid fee schedule amount. Payment will be approved pursuant to the criteria in subrule 78.10(5).

m. Bathtub/shower chair, bench. Payment will be approved pursuant to the criteria in subrule 78.10(5).

n. Patient lift, nonstandard. Payment will be approved pursuant to the criteria in subrule 78.10(5).

o. Power wheelchair attendant control. Payment will be approved pursuant to the criteria in subrule 78.10(5).

p. Shower commode chair. Payment will be approved pursuant to the criteria in subrule 78.10(5).

q. Ventilator, secondary. Payment will be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs, subject to the requirements of paragraph 78.10(2)*"d."*

78.28(2) Notwithstanding the provisions of paragraph 78.28(1)*"a,"* under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

a. Buprenorphine,

b. Buprenorphine and naloxone combination,

c. Methadone,

d. Naltrexone, and

e. Naloxone.

For the purpose of this subrule, "medication-assisted treatment" means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services requiring prior approval are outlined in the Iowa Medicaid Dental Provider Manual as amended to July 1, 2026.

78.28(4) Optometric services and ophthalmic materials that must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment will be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval will be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval will be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient pursuant to rule 441—78.7(249A) and subrule 78.1(18).

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department will approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid.

b. A hearing aid costing more than $650. The department will approve payment for either of the following purposes:

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services requiring prior approval, preprocedure review or preadmission review are outlined in the Acute Hospitals Provider Manual as amended to July 1, 2026.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as set forth in the Ambulatory Surgical Centers Provider Manual as amended to July 1, 2026.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval will be granted if ACT services are determined to be medically necessary. Approval will be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and will be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and will be approved if determined to be medically necessary. Payment will be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and that are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically

necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services will be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and will be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

78.28(11) Replacement of vibrotactile aids less than four years old will be approved when the original aid is broken beyond repair or lost.

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12)*"b,"* the following radiology procedures require prior approval:

(1) Magnetic resonance imaging (MRIs);

(2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;

(3) Computed tomographic angiographs (CTAs);

(4) Positron emission tomography (PETs); and

(5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12)*"a,"* prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on an Outpatient Prior Authorization Request form and approved before any claim for payment is submitted.

441—78.29(249A) Behavioral health services. Payment will be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment will be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services as outlined in the Birth Centers Provider Manual as amended to July 1, 2026.

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital. Hospitals with alternate sites approved by the department of inspections, appeals, and licensing are acceptable sites. All outpatient services listed in paragraphs 78.31(1)*"g"* through *"m"* are subject to a random sample retrospective review for medical necessity by Iowa Medicaid. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs 78.31(1)*"a"* through *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs 78.31(1)*"g"* through *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.

b. Outpatient surgery.

c. Laboratory, X-ray and other diagnostic services.

d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Substance use disorder.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the VFC program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) *Application for certification.* Hospital outpatient programs listed in paragraphs 78.31(1) *"g"* through *"m"* must submit an application to Iowa Medicaid for certification before payment will be made. Iowa Medicaid will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Substance use disorder.

(1) Approval by joint commission. In addition to certification by the department, substance use disorder programs must also be approved by the joint commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, sex, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance use counselor certified by the Iowa board of certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted that shall include:

1. A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.
2. A comprehensive medical history and physical examination including the history of physical problems associated with dependence.
3. Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.
4. Any history of physical abuse.
5. A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.
6. A determination of current and past psychiatric and psychological abnormality.
7. A determination of any degree of danger to self or others.
8. The family's history of substance use disorders.
9. The patient's educational level, vocational status, and job performance history.
10. The patient's social support networks, including family and peer relationships.
11. The patient's perception of the patient's strengths, problem areas, and dependencies.
12. The patient's leisure, recreational, or vocational interests and hobbies.
13. The patient's ability to participate with peers and in programs and social activities.

14. Interviews of family members and significant others as available with the patient's written or verbal permission.

15. The patient's legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

1. Alcohol or drugs taken in greater amounts over a longer period than the person intended.

2. Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

3. Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

4. Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

5. Characteristic withdrawal symptoms.

6. Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient, there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall include documentation of:

1. The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs.

2. The patient's participation in the development of the treatment plan.

3. Changes in treatment.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care that meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

2. The plan is in accordance with the patient's reassessed needs at the time of transfer.

3. The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

5. Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level. If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience,

a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

1. A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

2. A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

3. A history of exercise behavior, including type, frequency, and duration.

4. A complete history of current alcohol and other drug use.

5. Any suicidal thoughts or attempts.

6. Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

7. History of experiencing physical or sexual (incest or rape) abuse.

8. History of other counseling experiences.

9. Appropriate psychological assessment, including psychological orientation to the above questions.

10. A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

11. Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

12. The patient's social support networks, including family and peer relationships.

13. The patient's educational level, vocational status, and job or school performance history, as appropriate.

14. The patient's leisure, recreational, or vocational interests and hobbies.

15. The patient's ability to participate with peers and programs and social activities.

16. Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

17. Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the DSM (Diagnostic and Statistical Manual of Mental Disorders as amended to July 1, 2026) published by the American Psychiatric Association. In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred. The need for treatment may be further substantiated by substance use, out-of-control spending, incidence of stealing to support habit, or compulsive gambling. The symptoms shall have been present for at least six months and three of the following criteria must be present:

1. Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

2. Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

3. Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

4. Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

5. Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

6. Ear, nose, and throat factors including headaches or dizziness.

7. Skin considerations including lanugo or dry skin.

8. Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient, there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall document:

1. The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs.

2. The patient's participation in the development of the treatment plans.

3. Changes in treatment.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance use patients in subparagraph 78.31(4)*"a"*(7).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

1. At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

2. A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

3. A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

4. A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

5. A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

6. A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

1. Postmyocardial infarction (within three months postdischarge).
2. Postcardiac surgery (within three months postdischarge).
3. Poststreptokinase.
4. Postpercutaneous transluminal angioplasty (within three months postdischarge).
5. Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

1. Referral form.
2. Physician's orders.
3. Laboratory reports.
4. Electrocardiogram reports.
5. History and physical examination.
6. Angiogram report, if applicable.
7. Operative report, if applicable.
8. Preadmission interview.
9. Exercise prescription.
10. Rehabilitation plan, including participant's goals.
11. Documentation for exercise sessions and progress notes.
12. Nurse's progress reports.
13. Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral. The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—24.1(225A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, including:

1. A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.
2. A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.
3. Any history of physical abuse.
4. A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.
5. A determination of current and past psychiatric and psychological abnormality.
6. A determination of any degree of danger to self or others.
7. The family's history of mental health problems.
8. The patient's educational level, vocational status, and job performance history.
9. The patient's social support network, including family and peer relationship.
10. The patient's perception of the patient's strengths, problem areas, and dependencies.
11. The patient's leisure, recreational or vocational interests and hobbies.
12. The patient's ability to participate with peers in programs and social activities.
13. Interview of family members and significant others, as available, with the patient's written or verbal permission.
14. Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type that cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

- Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.
- Service components may include individual and group therapy, reality orientation, stress management and medication management.
- Services are provided for a period for four to eight hours per day.
- Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.
- Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.
- Services are structured with an emphasis on program variation according to individual need.
- Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered, except as indicated:

1. Activity therapies, group activities, or other services and programs that are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

2. Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

3. Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them

are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

1. The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.
2. The person must be free of any underlying psychosis or severe neurosis.
3. The person cannot be toxic on any addictive drugs.
4. The person must be capable of self-care, including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall document:

1. The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs.
2. The patient's participation in the development of the treatment plan.
3. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care that meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

2. The plan is in accordance with the patient's reassessed needs at the time of transfer.

3. The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) General characteristics. An outpatient diabetes self-management education program shall provide instruction that will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(2) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(3) Admission criteria. Candidates for the program shall meet the following guidelines:

1. The person must have Type I or Type II diabetes.

2. The person must be referred by the attending physician.

3. The person shall demonstrate an ability to follow through with self-management.

(4) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(5) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

1. A diagnostic workup that entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

2. Behavioral considerations, including an emotional screening assessment and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD); having cardiac stability and social, family, and financial resources; having the ability to tolerate periods of sitting time; and being a nonsmoker for six months or, if a smoker, willingness to quit and having a physician's order to participate anyway. Factors that would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase. Changes in treatment must be documented. Components of pulmonary rehabilitation to be included are:

1. Physical therapy and relaxation techniques,
2. Exercise conditioning or physical conditioning for those with exercise limitations,
3. Respiratory therapy, education, an emphasis on the importance of smoking cessation, and
4. Nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are eligible to receive services under the HCBS intellectual disability waiver or children's mental health waiver.

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. For the purposes of this rule, "HCBS Provider Manual" means the department's manual that outlines provider-specific policies applicable to providers of HCBS services. The manual is available on the department's website. All references to the HCBS Provider Manual herein are as amended to July 1, 2026.

78.34(1) *Home maintenance support services.* Home maintenance support services encompass assistance required to maintain the participant's home as a clean, sanitary, and safe environment, provided when neither the participant nor any household person is capable of performing these tasks and no other relative, caregiver, or landlord is responsible for them. These services are particularly essential when the participant lives alone or when the usual caregiver needs support in performing these functions. "Usual caregiver" means an unpaid person who resides with the member and is available on a 24-hour per-day basis to assume responsibility for the care of the member.

a. These may involve tasks such as:

(1) Essential shopping, such as shopping for basic need items such as food, clothing or personal care items, or drugs.

(2) Limited housecleaning, such as maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and washing dishes.

(3) Window and door maintenance, such as hanging screen windows and doors, replacing window panes, and washing windows.

(4) Minor repairs to walls, floors, stairs, railings, and handles.

(5) Heavy cleaning, such as cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal.

(6) Mowing lawns and removing snow and ice from sidewalks and driveways.

(7) Tree or bush trimming when the tree or bush impairs safe navigation of the exterior of the home.

(8) Pest eradication and one-time cleaning following the pest eradication necessary for the person's health and safety.

b. Excluded services and costs. Services, activities, costs, and time that are not covered include but are not limited to:

(1) Tree trimming.

(2) Trash burning.

(3) Tree removal.

78.34(2) *Home health aide services.* Home health aide services are an extension of the state plan and are personal or direct care services provided to the member in the member's home that are not otherwise payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. A visit is defined as 15 minutes to 120 minutes.

a. Components of the service include but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a member with bath, shampoo, or oral hygiene.

(3) Helping a member with toileting.

(4) Helping a member in and out of bed and with ambulation.

(5) Helping a member reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician that are ordinarily self-administered.

(7) Performing incidental household services that are essential to the member's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group or an individual's home environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center or in the home due to the absence of the primary caregiver.

a. Supports provided during day care are protective oversight, supervision, and support with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Included are personal care (i.e., ambulation, toileting, feeding, assisting with medications), behavioral support, or intermittent health-related cares not otherwise paid under other waiver or state plan programs.

b. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day).

78.34(4) *Nursing care services.* Nursing care services are services that are included in the plan of treatment approved by the physician and that are provided by licensed nurses to members in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is an attendant care or supported community living provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health and substance use disorder services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225A) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability

or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Attendant care service.* Attendant care services are service activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)*"f"* and the skilled activities listed in paragraph 78.34(7)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date an HCBS Attendant Care Agreement to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled attendant care services shall be provided under the supervision of the member's physician or a licensed nurse or licensed therapist working under the direction of the member's physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Attendant Care Service Record or use a form prescribed by the department. Any service component that is not documented in accordance with rule 441—79.3(249A) will not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled attendant care service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including but not limited to bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting for medical needs that make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school or work setting.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school or work.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost will be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment will be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

i. Payment for home and vehicle modifications are limited to the service limitations published on the Iowa Medicaid fee schedule webpage.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year will be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year will be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academies of Sciences, Engineering, and Medicine. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The CCO is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13)*"g"* and employer authority tasks identified in paragraph 78.34(13)*"h,"* or who delegates the budget or employer authority tasks identified in paragraph 78.34(13)*"i."* Components of this service are set forth below.

a. Agreement. As a condition of participating in the CCO, a member shall sign the HCBS Consumer Choices Informed Consent and Risk Agreement to document that the member has been informed of the responsibilities and risks of electing the CCO.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability, elderly, AIDS/HIV, brain injury, and physical disability waivers are outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will determine an average unit cost for each service outlined in the HCBS Provider Manual based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department will apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department will compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor will be no lower than 60 percent.

(5) Individual budgets for respite services will be computed based on the average cost for services outlined in the HCBS Provider Manual. Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). The anticipated costs may include

the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by Iowa Medicaid or the MCO as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the CCO, a member must choose to hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the CCO may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's

service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Items and services not covered by the individual budget are outlined in the HCBS Provider Manual.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by Iowa Medicaid or the member's MCO. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment as outlined in the HCBS Provider Manual.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's MCO for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.
5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or MCO to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13)*"i."*

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.

(2) Verify employee qualifications.

(3) Specify additional employee qualifications.

(4) Determine employee duties.

(5) Determine employee wages and benefits.

(6) Schedule employees.

(7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)*"g"* and employer authority tasks identified in paragraph 78.34(13)*"h."* Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the CCO shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455 as amended to July 1, 2026. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act as amended to July 1, 2026, and is not eligible to receive federal funds.

(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet or use a form prescribed by the department. All other employees shall complete, sign and date the Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)*"m"*(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) *General service standards.* All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

441—78.35(249A) Occupational therapist services. Payment will be approved for the services provided by an occupational therapist that follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA; are reasonable and necessary to the treatment of the patient's illness or injury; and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"c."*

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

(7) Home maintenance support and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is

separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) Curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Home maintenance support and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the

individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, the Election of Medicaid Hospice Benefit form, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. A Revocation of Medicaid Hospice Benefit form is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.37(2) *Personal emergency response or portable locator system.* A personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Home maintenance support services.* Home maintenance support services are activities provided pursuant to subrule 78.34(1).

78.37(5) *Nursing care services.* Nursing care services are an extension of the State Plan, are included in the plan of treatment approved by the physician, and are provided by licensed agency nurses to members in the home or community. The services are reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the board of nursing. A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are service activities provided pursuant to subrule 78.34(5).

78.37(7) *Home-delivered meals.* Home-delivered meals are meals provided pursuant to subrule 78.34(11).

78.37(8) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.37(9) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(10) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.37(11) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.37(12) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled.

78.37(13) *Assisted living service.* The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental

supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved attendant care agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized attendant care service.

78.37(14) *General service standards.* All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process detailed in paragraph 78.31(14)*"e"* will apply.

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225A) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Home maintenance support services.* Home maintenance support services are service activities provided pursuant to subrule 78.34(1).

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

78.38(6) *Home-delivered meals.* Home-delivered meals are meals provided pursuant to subrule 78.34(11).

78.38(7) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.38(8) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.38(9) *CCO.* The CCO are service activities provided pursuant to subrule 78.34(13).

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

441—78.39(249A) Federally qualified health centers. Payment will be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act as amended to July 1, 2026.

78.39(1) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.39(2) *Risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.39(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.40(249A) ARNPs. Payment will be approved for services provided by ARNPs within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment will be made to ARNPs directly, without regard to whether the ARNP is employed by or associated with a physician, hospital, birth center, clinic, or other health care provider recognized under state law. An established protocol between a physician and the ARNP will not cause an ARNP to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment will be approved for services rendered in any location in which the ARNP is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, other clinics, and emergency rooms.

78.40(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, an ARNP must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) *Prenatal risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal care services, home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities that assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities that assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities that assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities that assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities that assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

(3) Intensive residential services are supported community living services provided 24 hours per day to members with a serious and persistent mental illness diagnosis residing in a designated intensive residential service home. To be eligible for supported community living intensive residential services, the member must meet the eligibility criteria in paragraph 78.27(7)*"c."*

(4) Supported community living services delivered through the remote supports modality must meet the requirements pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

(5) Supported community living services delivered in a host home by a subcontractor of the supported community living services agency must meet the requirements pursuant to HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Additional criteria for receiving supported community living services for transition-age youth 16 to 18 years of age.

(1) Members residing in the family home may receive supported community living services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily supported community living in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.30(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Members 16 to 18 years of age shall receive 24-hour site supervision and support.
- Members under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member's parent or guardian has consented to supported community living services.

4. The member is able to pay room and board costs (funding sources may include but are not limited to supplemental security income, child support, adoptions subsidy, or private funds).

f. Youth under the age of 16 needing supported community living outside the family home must receive services in a licensed or certified residential-based supported community living setting.

g. Maintenance and room and board costs are not reimbursable.

h. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures.

i. A unit of service is:

(1) One full calendar day when a member receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)*"g"*(1) does not apply.

j. The maximum number of units available per member per year are listed on the Iowa Medicaid fee schedule webpage.

k. The service shall be identified in the member's service plan.

l. Supported community living services will not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the waiver.

78.41(2) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

78.41(3) *Personal emergency response or portable locator system.* The personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the member's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.41(9) *IMMT services.* IMMT services are activities performed pursuant to subrule 78.34(8).

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a certified residential-based supported community living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or assist in developing self-help skills for maximum independence.

a. Allowable service components are:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.40(22)*"d."*

f. Residential-based supported community living services will not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day. A day is 24 hours of supervision and support.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) *Vaccines administered to children.* Payment will be made to an enrolled provider for an administration fee for vaccines available through the VFC program administered by the department if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) *Vaccines administered to adults.* Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) *Verification and reporting.* Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

441—78.43(249A) HCBS brain injury waiver services. Payment will be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and

receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of members and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the member to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the member so that the abilities, needs and desires of the member can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual members.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided pursuant to subrule 78.41(1).

78.43(3) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(4) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.43(5) *Personal emergency response or portable locator system.* A personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.43(6) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(7) *Specialized medical equipment.*

a. Specialized medical equipment includes medically necessary items that are for personal use by members with a brain injury and that:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service not to exceed the service limitations published on the Iowa Medicaid fee schedule webpage.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items will be based on a fee schedule. The amount of the fee will be determined as directed in 441—subrule 79.1(17).

78.43(8) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.43(9) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives, or who routinely provide care to the member to increase the member's or family members' capabilities to maintain and care for the member in the community. Counseling may include helping the member or the member's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Family may include spouse, children, friends, or in-laws of the member. Family does not include individuals who are employed to care for the member.

78.43(10) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(11) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors which have interfered with the member's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the individual treatment plan.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(12) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.43(13) *IMMT services.* IMMT services are activities performed pursuant to subrule 78.34(8).

78.43(14) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.43(15) *General service standards.* All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

441—78.44(249A) Lead inspection services. Payment will be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the DSM, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, ARNP, or PA.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, ARNP, or PA to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance use. This service consists of direct counseling for treatment of mental health and substance use symptoms by a psychiatrist, licensed mental health professional, ARNP, PA, or substance use specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance use counselor, peer specialist, community support specialist, ARNP, or PA.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance use counselor, peer specialist, community support specialist, ARNP, or PA. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance use counselor, community support specialist, case manager, ARNP, or PA, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance use counselor, community support specialist, case manager, ARNP, or PA. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

441—78.46(249A) Physical disability waiver service. Payment will be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.46(2) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.46(3) *Personal emergency response or portable locator system.* A personal emergency response or portable locator are services provided pursuant to subrule 78.34(10).

78.46(4) *Specialized medical equipment.* Specialized medical equipment are provided pursuant to subrule 78.43(8).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for

Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring

of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the VFC program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment will be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the department, Iowa Child Health Specialty Clinics, and the department of education.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment will also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular

No. A-87 as amended to July 1, 2026, or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee will determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

b. The infant and toddler program provider shall sign and return a Medicaid Billing Remittance form along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

441—78.50(249A) Local education agency services. Subject to the following subrules, payment will be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include but are not limited to audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the VFC program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies will be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act as amended to July 1, 2026, payment for transportation between home and school is not a covered service.

78.50(2) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(3) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

b. The local education agency provider shall sign and return a Medicaid Billing Remittance form along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

441—78.51(249A) Indian health service 638 facility services. Payment will be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.47(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items will be based on a fee schedule. The amount of the fee will be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225A) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1,500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager will maintain a signed statement that potential community resources are unavailable and will list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

441—78.53(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act as amended to July 1, 2026 (Medicare).

441—78.54(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 481—655.9(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

441—78.55(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.55(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.55(2) *Member eligibility.* To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment as amended to July 1, 2026, completed by a qualified trained assessor. The assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and Iowa Medicaid or the member's MCO has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance use.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.55(3) *Covered services.*

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections, appeals, and licensing; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an ICF/ID, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLs;

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance use and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

(1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Compensatory strategies to assist in managing ADLs;

(4) Behavioral supports;

(5) Assistance with obtaining and use of assistive technology;

(6) Assistance with the self-identification of antecedent triggers;

(7) Flexibility in programming to meet the member's individual needs;

(8) Assistance with re-learning coping and compensatory strategies;

(9) Assistance with the development and application of self-advocacy skills to navigate the service system;

(10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to Iowa Medicaid for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to Iowa Medicaid.

(1) Iowa Medicaid will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. Iowa Medicaid may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.55(4) and to the conditions pursuant to subrule 78.55(3).

g. Quality review. Iowa Medicaid may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.53(249A).

78.55(4) *Medical necessity.* Nothing in this rule will be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

78.55(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

441—78.56(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.56(1) Nursing services are services that are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.56(2) Personal care services are those services that are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.56(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.56(4) Developmental therapies are those services that are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.56(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.56(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is

responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

(1) Place of service.
(2) Type of service to be rendered and the treatment modalities being used.
(3) Frequency of the services.
(4) Assistance devices to be used.
(5) Date on which services were initiated.
(6) Progress of member in response to treatment.
(7) Medical supplies to be furnished.
(8) Member's medical condition as reflected by the following information, if applicable:
1. Dates of prior hospitalization.
2. Dates of prior surgery.
3. Date last seen by a primary care provider.
4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
5. Prognosis.
6. Functional limitations.
7. Vital signs reading.
8. Date of last episode of acute recurrence of illness or symptoms.
9. Medications.
(9) Discipline of the person providing the service.
(10) Certification period.
(11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
(12) The appropriate department form is utilized during the prior authorization review.

78.56(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

f. Services provided to a member while the member is in institutional care.

441—78.57(249A) Qualified Medicare beneficiary (QMB) provider services.

78.57(1) *Payment.* Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.57(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicare cost sharing" means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program,

Medicaid pays the individual's Medicare Part A and B premiums, coinsurance, copayment, and deductible (except for Part D).

441—78.58(249A) Health insurance premium payment (HIPP) provider services.

78.58(1) *Reimbursement.* A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.58(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Cost sharing" means the member's health insurance in-network responsibility for a covered service. "Cost sharing" includes coinsurance, copayments, and deductibles.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Eligible member" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"Health insurance premium payment program" or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

441—78.59(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.54(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24.

441—78.60(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

These rules are intended to implement Iowa Code chapter 249A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 79
"Other Policies Relating to Providers of Medical and Remedial Care"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 124 and 249A and Public Laws 111.5 and 109-177

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter provides information for providers about Iowa's Medicaid program, including the following:

- Provider reimbursement methodology;
- Provider sanctions;
- Medical record maintenance;
- Reviews and audits;
- Provider agreements;
- The Medical Assistance Advisory Council;
- Requirements for prior-authorization, preadmission review, and preprocedure surgical review;
- Provider enrollment;
- Requirements for participating laboratories; and
- Requirements for providers prescribing controlled substances.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of its review, the Department eliminated restrictive terms and outdated terminology, information, dates, and system references; added dates certain; standardized references to the Department pursuant to government realignment; and updated provisions to match current Department practice and policy. The Department also deleted references to Iowa Code sections repealed by 2024 Iowa Acts, House File 2673.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

Health care providers may incur administrative costs to comply with this proposed chapter.

- **Classes of persons that will benefit from the proposed rulemaking:**

Health care providers that participate or apply for participation in Iowa's Medicaid program, as well as Iowa Medicaid members, will benefit from the guidance and structure provided in this proposed chapter.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

As of June 23, 2025, Iowa Medicaid has 72,358 participating providers representing 69 distinct provider types.

- **Qualitative description of impact:**

This proposed chapter provides needed information to providers that participate in Iowa Medicaid or that want to apply to participate in Iowa Medicaid.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to enforce this proposed chapter.

- **Anticipated effect on State revenues:**

This proposed chapter has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

This proposed rulemaking is both required and needed in order to maintain a network of health care providers meeting State and federal standards and requirements.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 79 and adopt the following **new** chapter in lieu thereof:

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" or "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" as defined in Iowa Code section 514B.1.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per unit rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made on July 1 of each year.

There are some variations in this methodology that are applicable to certain providers. These are set forth below in subrules 79.1(3) through 79.1(8) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website.

d. Reserved.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider based on projected or historical

costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers that have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers that have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to paragraph 79.1(15)*"f."*

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs will be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h"* for more information.

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

i. Inflation factor. When the department's reimbursement methodology for any provider includes an inflation factor, this inflation factor will not exceed the amount by which the consumer price index for all urban consumers increased during the most recent calendar year.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 7/1/21.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Applied behavior analysis	Fee schedule	Fee schedule in effect 7/1/22.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/22.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule. See 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: $21.11 per 15-minute unit.
Community mental health centers	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

Provider category	Basis of reimbursement	Upper limit
		3. In the case of services provided pursuant to a contract between an FQHC and an MCO, reimbursement from the MCO will be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule	Effective 7/1/22, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/22 rate: Veterans Administration contract rate or $1.58 per 15-minute unit, $25.33 per half day, $50.44 per full day, or $75.63 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22, for intellectual disability waiver: The provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute or half-day rate. If no 6/30/22 rate, $2.12 per 15-minute unit or $33.76 per half day. For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: Initial one-time fee: $56.18. Ongoing monthly fee: $43.69.
Portable locator system	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: Initial one-time fee: $56.18. Ongoing monthly fee: $43.69.
3. Home health aides	Fee schedule	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25% or maximum Medicaid rate in effect 6/30/22 plus 4.25%. For intellectual disability waiver effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25% or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.61 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/22, provider's

Provider category	Basis of reimbursement	Upper limit
		rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $94.98 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, not to exceed $340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, not to exceed $340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $9.67 per 15-minute unit, not to exceed $340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.16 per 15-minute unit, not to exceed $340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $9.67 per 15-minute unit, not to exceed $340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.16 per 15-minute unit, not to exceed $340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Facility care:		

Provider category	Basis of reimbursement	Upper limit
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Adult day care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $4.37 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $8.75 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/22: $1,145.48 lifetime maximum. For intellectual disability waiver effective 7/1/22: $5,727.37 lifetime maximum. For brain injury, health and disability, and physical disability

Provider category	Basis of reimbursement	Upper limit
		waivers effective 7/1/22: $6,872.85 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Fee schedule in effect 7/1/22.
12. Nutritional counseling	Fee schedule	Effective 7/1/22 for non-county contract: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $9.46 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/22: $124.81 per unit.
14. Senior companion	Fee schedule	Effective 7/1/22 for non-county contract: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $2.04 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.78 per 15-minute unit, not to exceed $133.70 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.78 per 15-minute unit, not to exceed $133.70 per day.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $12.36 per 15-minute unit.
Group	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $12.35 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/22, provider's rate in effect 6/30/22 plus 4.25%.
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/22: $10.02 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 11.727%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/22: $10.02 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported

Provider category	Basis of reimbursement	Upper limit
		employment services not to exceed $3,302.53 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/22. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/22, $6,872.85 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $12.36 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $12.35 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/22.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Fee schedule	Effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Fee schedule	Effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $10.02 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 11.727%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22: The fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.78 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/22, $6,872.85 per year.

Provider category	Basis of reimbursement	Upper limit
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $10.02 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $26.82 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $74.46 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $17.35 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	$28.16 per day.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule	Effective 7/1/22: Fee schedule in effect 6/30/22 plus 4.25%.
2. Home-based habilitation	Fee schedule	Fee schedule in effect 7/1/22.
3. Day habilitation	Fee schedule	Effective 7/1/22: $3.57 per 15-minute unit or $69.40 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect 7/1/22.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.

Provider category	Basis of reimbursement	Upper limit
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/22. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Individual placement and support supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.5(11)*"q"*	Effective 7/1/22: The Medicaid LUPA fee schedule rate published on the department's website.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 10/1/2021.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 1/1/2021.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)*"h"*	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare).
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.4(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:	Prospective reimbursement.	

Provider category	Basis of reimbursement	Upper limit
1. Nursing facility care	See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—81.5(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.5(16)*"f"*(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—81.5(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.5(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q."*	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q."*	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)*"d"*	Fee schedule in effect 7/1/17. See 79.1(7)*"d."*
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)*"c"*	Rate provided by 79.1(7)*"c."*
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children: 1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/21: Non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q."*	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and an MCO, reimbursement from the MCO will be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment will be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)*"n."*

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" means a Medicaid patient 17 years or younger.

"Adult" means a Medicaid patient 18 years or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2019, and before January 1, 2020, except as noted in paragraph 79.1(5)*"x."* Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" means the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount will be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" means case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report will not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" means an add-on to the blended base amount, which will compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80

percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" means an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" means hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" means cases that have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections, appeals, and licensing pursuant to rule 481—51.27(135B).

"Diagnosis-related group" or *"DRG"* means a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs will be made from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by a factor to maintain expenditures within the amount

appropriated to the department for this purpose. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" means a payment that will compensate for treatment of a disproportionate share of poor patients. The disproportionate share payment will be made directly from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

"Disproportionate share percentage" means either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See subparagraph 79.1(5)*"y"*(7) for more information.)

A separate disproportionate share percentage will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case, coded as a transfer to another hospital, will be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report period. The claim set is updated in July of every third year and is modeled using recalibrated rates pursuant to paragraph 79.1(5)*"r."*

"GME/DSH fund implementation year" means 2022.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" means a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of

full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" means those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" means cases that have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in paragraph 79.1(5)*"f."*

"Low-income utilization rate" means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate will be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2018, through December 31, 2019, and paid through March 31, 2020.

"Medicaid inpatient utilization rate" means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate will be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" means a designated level II or level III neonatal unit.

"Net discharges" means total discharges minus transfers and short stay outliers.

"Rate table listing" means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by a hospital before being multiplied by the appropriate DRG weight.

"Rebasing" means the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2021 and every three years thereafter.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" means cases that have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in paragraph 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to paragraph 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The

second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to paragraph 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2021, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid cost data less medical education from the Medicaid claim set using trimmed claims. Medicaid cost data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions pursuant to paragraph 79.1(5)*"b."* Weights are determined through the following calculations:

1. Determine the statewide geometric mean cost for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean cost for each DRG by multiplying the statewide geometric mean cost for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean costs for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean cost for all DRGs.
4. Divide the statewide geometric mean cost for each DRG by the weighted average geometric mean cost for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index will be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation will use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose:

1. The total calculated dollar expenditures based on hospitals' base year cost reports for capital costs and medical education costs, multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base year cost report or MMIS claims system, the actual dollar expenditures for capital costs, and direct medical education costs multiplied by an amount to maintain expenditures within the amount appropriated to the department for this purpose, and then subtracting payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge will be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base year cost report by 80 percent and then multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs will be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid

patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Reserved.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. One hundred percent of outlier costs will be paid to facilities at the time of claim reimbursement. Iowa Medicaid will perform retrospective outlier reviews.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers will be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to Iowa Medicaid review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts will be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by Iowa Medicaid must submit all requested supporting data to Iowa Medicaid within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to Iowa Medicaid within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units.

When a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay will be combined with the claim for the original inpatient stay and payment will be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units, psychiatric units, and acute psychiatric intensive care services. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base year per diem rate to which a factor to maintain expenditures within the amount appropriated to the department for this purpose is applied.

(1) Per diem calculation. The base rate will be the medical assistance per diem rate as determined by the individual hospital's base year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Per diem reimbursement. Hospitals will be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate will be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(3) Per diem recalculation. Hospital prospective reimbursement rates will be established based on the state's fiscal year.

(4) Acute psychiatric intensive care services. Services that meet the criteria at 441—subrule 78.3(8) will be reimbursed as follows:

1. Services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific per diem rate as calculated pursuant to subparagraph 79.1(5)*"i"*(1) plus a percentage increase as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

2. Services not provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific DRG payment rate as calculated pursuant to paragraph 79.1(5)*"b"* plus an add-on per diem rate as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

(5) Per diem billing. The current method for submitting billing and cost reports will be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415 as amended to July 1, 2026, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment.

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors will be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts will be rebased and weights recalibrated in 2021 and every three years thereafter. Cost reports used in rebasing will be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to Iowa Medicaid by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund will be updated as provided in subparagraphs 79.1(5)*"y"*(3), *"y"*(6), and *"y"*(9).

(4) Hospitals receiving reimbursement as critical access hospitals will not receive inflation of base payment amounts and will not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Out-of-state hospitals do not qualify for disproportionate share payments.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that Iowa Medicaid reviews short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by Iowa Medicaid. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly to Iowa Medicaid and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through Iowa Medicaid will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to Iowa Medicaid after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by Iowa Medicaid as described in paragraph 79.1(5)*"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to Iowa Medicaid at the department's address. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by Iowa Medicaid, reimbursement will be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* will be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by Iowa Medicaid to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid at the department's address, with documentation that the certification requirements are met. Iowa Medicaid will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital will be retroactive to the first day of the month during which Iowa Medicaid received the request for certification. No additional retroactive payment adjustment will be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)*"b"*(1) if the unit's program is licensed by the department as a substance abuse treatment program in accordance with Iowa Code chapter 125. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission or the American Osteopathic Association. Iowa Medicaid will verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the department pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if the physical rehabilitation hospital or unit receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 CFR Subpart P as amended to July 1, 2026, and the hospital is accredited by the Joint Commission or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36 has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272, both as amended to July 1, 2026.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American Council on Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $0.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital

disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. Reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15) as amended to July 1, 2026. Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment will be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights pursuant to paragraph 79.1(5)*"r"* for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights, pursuant to paragraph 79.1(5)*"r,"* for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph 79.5(1)*"y"*(10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals or (2) 2 ½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition but do not qualify under the low-income utilization rate definition, the disproportionate share percentage will be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage will be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act as amended to July 1, 2026, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital will be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights, pursuant to paragraph 79.1(5)*"r,"* for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights, pursuant to 79.1(5)*"r,"* for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age will be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234 as amended to July 1, 2026) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments, pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v,"* cannot exceed the amount of the federal cap under Public Law 102-234 as amended to July 1, 2026.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions.

A hospital wishing to qualify for disproportionate share payments as a children's hospital must provide the following information to Iowa Medicaid within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Reserved.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals, pursuant to paragraphs 79.1(5)*"a"* through *"z,"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* through *"z."* Amounts paid before adjustment that exceed reasonable costs will be recovered by the department.

(1) The base rate upon which the DRG payment is built will be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to Iowa Medicaid and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment will not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv) as amended to July 1, 2026, if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share will be funds generated from tax levy collections of the county or city in which the hospital is located and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year will apply.

(3) Amount of payment. The total amount of disproportionate share payments made, pursuant to paragraph 79.1(5)*"y,"* and the rural hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American

Medical Association as amended to July 1, 2026. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the CPT as amended to July 1, 2026. Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* will be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting as opposed to the physician's office. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following (consistent with "POS" definitions under Medicare per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, amended to July 1, 2026):

(1) Telehealth (POS 02).
(2) Outpatient hospital-off campus (POS 19).
(3) Inpatient hospital (POS 21).
(4) Outpatient hospital-on campus (POS 22).
(5) Emergency room-hospital (POS 23).
(6) Ambulatory surgical center (POS 24).
(7) Military treatment center (POS 26).
(8) Skilled nursing facility (POS 31).
(9) Hospice-for inpatient care (POS 34).
(10) Ambulance-land (POS 41).
(11) Ambulance-air or water (POS 42).
(12) Inpatient psychiatric facility (POS 51).
(13) Psychiatric facility-partial hospitalization (POS 52).
(14) Community mental health center (POS 53).
(15) Psychiatric residential treatment center (POS 56).
(16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. Primary care services that are eligible for payment, pursuant to this rule, will be paid at the greater of:

(1) The otherwise applicable Iowa Medicaid rate;

(2) The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

(3) The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009; or

(4) If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the CMS, pursuant to 42 CFR §447.405(a)(1), and in effect on June 30, 2014.

Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the Vaccines for Children Program will be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)*"c."* Anesthesia procedures listed in the fee schedule with a factor code of "F" are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee

schedule with a factor code of "A" are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. The Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount, which will be updated annually on January 1.

79.1(8) *Drugs.*

a. Except as provided in paragraphs 79.1(8)*"d"* through *"h,"* all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*;

2. The federal upper limit (FUL), defined as the upper limit for a multiple-source drug established in accordance with the methodology of CMA as described in 42 CFR 447.514(a)-(c) as amended to July 1, 2026, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"c"*;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*; or

4. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state-defined professional dispensing fee; or

3. Providers' usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC will be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys will be conducted at least once every six months or more often at the department's discretion. The average state AAC will be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department will be published on the department's website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span will be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee will be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey will be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose will be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)*"a,"* reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

2. The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, will be according to paragraph 79.1(8)*"a"* because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c";*

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 as amended to July 1, 2026, will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)*"a"* through *"f."* The pharmacy encounter rate is the current "outpatient per visit rate (excluding Medicare)" approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)*"a"* through *"f,"* payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, will be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment will be made for sales tax.

k. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) Reserved.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider will be made to anyone other than the providers. However, with respect to physicians, dentists or other individual practitioners, direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization, including a health maintenance organization that furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, that renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule will preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers, as specified in subrule 79.1(1), will not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau that, or an individual who, advances money to a provider for accounts receivable that have been assigned or sold or otherwise transferred, including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives, such as billing agents or accounting firms, that render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which, in the judgment of the Secretary of the Department of Health and Human Services, generally do not vary significantly in quality from one provider to another, the upper limits for payments will be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits will be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits will be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department will pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department will pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified will be charged to members for the following covered services:

a. The member shall pay a copayment of $1 for each covered prescription or refill of any covered drug.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment will not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility, the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate will be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care will be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) will not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS children's mental health waiver family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency under an HCBS intellectual disability waiver, brain injury waiver, or health and disability waiver.

a. Reporting requirements.

(1) Providers shall submit the completed certification form prescribed by the department. The provider shall email the report and required supplemental information to the email address specified on the form. The provider shall mail one signed copy of the certification page to Iowa Medicaid at the department's address, no later than the due date of the required electronic submissions.

(2) The provider shall submit a financial and statistical report coinciding with the provider's fiscal year.

(3) The provider shall submit the financial and statistical report on or before the last day of the third month following the end of the cost reporting period.

(4) A certified home health agency enrolled to deliver HCBS that is required to submit a Medicare cost report may request a 60-day extension for submitting the financial and statistical cost report. All other providers may request a 30-day extension for submitting the financial and statistical report. All requests must be submitted in writing to Iowa Medicaid by the financial and statistical report due date. No other extensions will be granted.

(5) If a provider terminates its participation in any HCBS program or service, the provider shall submit a final financial and statistical report on or before the sixtieth day following the date of termination for retrospective adjustment in accordance with subparagraph 79.1(15)*"f"*(1).

(6) Providers failing to submit a financial and statistical report that meets the requirements of this paragraph within the time frames set forth in subparagraph 79.1(1)*"a"*(3) or *"a"*(4), as applicable, will reduce payment to 76 percent of the current rate. The reduced rate will be paid for not longer than three months, after which time no further payments will be made.

(7) Providers shall submit a completed financial and statistical report in an electronic format that can be opened using the extension xls or xlsx. The provider shall submit supplemental documentation in a generally accepted business format.

(8) Along with its financial and statistical report, the provider shall include a working trial balance that corresponds to the data contained on the financial and statistical report. Financial and statistical reports submitted without a working trial balance will be considered incomplete.

(9) The provider's financial data within the financial and statistical report shall be based on the provider's financial records. When the records are not based on the accrual basis of accounting, the provider shall make adjustments necessary to convert the information to an accrual basis for reporting.

(10) Providers of multiple programs or services shall submit a cost allocation schedule. The schedule must identify an allocation method for each expense account, including the statistics used in the calculation.

(11) Providers shall not report costs to any waiver service that are costs of any other program or public or private funding sources, including but not limited to the Medicaid state plan; Medicare; other state, local or federal funded programs; and private funding sources. Providers shall not report costs of HCBS waiver services as a cost of any other public or private funding source.

(12) Iowa Medicaid or its designee may review or audit financial and statistical reports as filed to determine the actual cost of services in accordance with generally accepted accounting principles or Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, subject to the exceptions and limitations in the department's administrative rules and financial and statistical report instructions.

(13) Failure to maintain records to support the financial and statistical report and make them available to the department or its designee upon request may result in adjustment, payment reduction, or sanction including but not limited to termination of the provider's HCBS certification.

(14) When adjustments made to prior reports indicate noncompliance with reporting instructions or the provider has a history of inadequate documentation to support the financial and statistical report, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on the form specified by the department and have an approved service plan for the member.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Twenty percent identified cost limitation.

1. The following identified costs are not subject to the 20 percent limitation; however, the following costs are used to calculate the limitation:

- Wages, benefits, and payroll taxes.
- Direct care transportation expense—with and without member present.
- Direct care development, training, and supplies.
- Member-specific assistance.
- Member-specific equipment repair or purchase.

2. For each waiver service, the sum of reported costs not identified in numbered paragraph 79.1(15)*"b"*(3)"1" is limited to 20 percent of the identified costs in numbered paragraph 79.1(15)*"b"*(3)"1."

(4) Mileage reimbursement for business use of personal employee vehicles will be limited to the federal Internal Revenue Service's (IRS's) published mileage rate in effect during the cost reporting period.

(5) Compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function and do not exceed the maximum allowed compensation as described in numbered paragraphs 79.1(15)*"b"*(5)"5" and "6."

1. "Ownership" is defined as an interest of 5 percent or more. For this purpose, the following persons are considered immediate relatives: husband, wife, natural or adoptive parent, natural or adoptive child, natural or adoptive sibling, step-parent, step-child, step-sibling, parent-in-law, child-in-law, sibling-in-law, grandparent, or grandchild. Adequate time records shall be maintained.

2. "Compensation" means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred

compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest-issued W-2 and current compensation shall be required to be disclosed to Iowa Medicaid or its designee. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation will be considered unallowable for reimbursement. Providers shall report all compensation paid to related parties, including payroll taxes, on the financial and statistical report.

3. "Reasonableness" requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable providers, and depends upon the facts and circumstances of each case.

4. "Necessary" requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service and be pertinent to the operation and sound conduct of the institution.

5. The maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, is equal to the intermediate care facility for persons with an intellectual disability (ICF/ID) maximum compensation for facilities with 60 beds or more pursuant to 441—subparagraph 82.4(11)*"e"*(4).

6. The maximum allowed compensation for any other owner or immediate relative is 60 percent of the amount allowed in numbered paragraph 79.1(15)*"b"*(5)"5."

7. The provider shall maintain records in the same manner for an owner or immediate relative compensated by the agency as are maintained for any employee of the agency, including but not limited to employment records, timekeeping, and payroll records.

8. The maximum allowed compensation for owners and immediate relatives shall be adjusted by the percentage of the average workweek devoted to business activity during the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one owner or immediate relative allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one agency.

9. Costs applicable to services, facilities, and supplies furnished to the provider by a person or organization related to the provider by common ownership or control are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

- "Related" means that the agency, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
- Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.
- Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.
- A provider may lease a facility from a related person or organization. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its cost the costs of ownership of the facility. This includes depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.
- An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence that the criteria in numbered paragraph 79.1(15)*"b"*(5)"10" have been met.

10. The agency must demonstrate the following with convincing evidence. Where all of the conditions below are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

- The supplying organization is a bona fide separate organization;

- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and
- The charge to the agency is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

c. Prospective rates for new providers.

(1) "New providers" means providers who have not submitted an annual report including at least six months of actual, historical costs of operations for any service as listed in subrule 79.1(15).

(2) New providers will be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period.

(3) Projected costs of any new service, as listed in subrule 79.1(15), shall be submitted on the applicable form prescribed by the department.

(4) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

(5) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates will be determined as provided in paragraph 79.1(15)*"d."*

d. Prospective rates for established providers.

(1) "Established providers" means providers who have submitted an annual report including six months of actual, historical costs of operation.

(2) The prospective rate will be adjusted annually, effective the first day of the third month after the month during which the annual financial and statistical report is submitted to the department.

(3) The provider's prospective rate will be the lower of:

1. The provider's reasonable and proper actual cost-based rate as calculated by the provider's most recent financial and statistical report and adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end,

2. In the first year of reporting six months of actual, historical costs of operation, or a year in which the provider's base rate is recalculated, the base rate is equal to the amount calculated in numbered paragraph 79.1(15)*"d"*(3)"1,"

3. In a year in which the provider's base rate is not recalculated, the prior period base rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end, or

4. The upper rate limit pursuant to subrule 79.1(2).

(4) Recalculation of base rates (rebasing).

1. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency, the base rates will be recalculated based on the reasonable and proper actual costs of operation as calculated by the fiscal year 2022 financial and statistical report.

2. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency; and 15-minute HCBS intellectual disability waiver supported community living services, the base rates will be recalculated based on the reasonable and proper costs of operation for the provider's fiscal year ending on or after January 1, 2024.

3. Subsequent to the recalculation of base rates in numbered paragraph 79.1(15)*"d"*(4)"2," a provider's base rate will be recalculated no less than every three years.

(5) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

e. Reserved.

f. Retrospective adjustments.

(1) For fee for service, retrospective adjustments will be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for 15-minute HCBS intellectual disability waiver supported community living services; HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency under an HCBS intellectual disability waiver, brain injury waiver, and health and disability waiver, as reported on the applicable department form, subject to the upper rate limit allowed in subrule 79.1(2).

(2) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent for fee for service will be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) If a provider does not remit the amount of the overpayment identified in subparagraph 79.1(15)*"f"*(2) within 30 days after notice, the department will deduct the amount owed from future payments.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to July 1, 2026, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2024, means the hospital's cost report with fiscal year end on or after January 1, 2022, and before January 1, 2023. Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" means the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in determining the statewide base APC rate.

"Cost outlier" means services provided during a single visit that have an extraordinarily high cost as established in paragraph 79.1(16)*"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" or *"CPT"* is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly. For the purposes of this rule, "CPT" means the coding as amended to July 1, 2026.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports in determining the direct medical education rate.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the factor used to limit aggregate expenditures to available funding and then divided by the sum of outpatient relative discounted APC weights.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report. The claim set is updated every three years in July and is modeled using recalibrated weights pursuant to paragraph 79.1(5)*"r."*

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the CPT and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2019, through December 31, 2020, and paid through March 31, 2020.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 as amended to July 1, 2026, and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 as amended to July 1, 2026.

"Outpatient visit" means those hospital-based outpatient services that are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Rebasing" means the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" means the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to July 1, 2026, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services (CMS) to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to July 1, 2026, is eligible for combined billing status if the hospital has filed the approval notice with Iowa Medicaid. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services will be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services will be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight will be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs will be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Separately payable clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Separately payable nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E1	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
E2	Items, codes, and services: ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."*

Indicator	Item, Code, or Service	OPPS Payment Status
		If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J1	Hospital Part B services paid through a comprehensive APC	If covered by Iowa Medicaid, the service is paid under OPPS APC. All covered Part B services on the claim, except services with OPPS SI=F, G, H, L, and U; ambulance services; diagnostic and screening mammography; and all preventive services. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J2	Hospital Part B services that may be paid through a comprehensive APC	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. ● In other circumstances, payment is made through a separate APC payment. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STV-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," or "V." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
		● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS APC. ● Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. ● In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS APC or Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* ● Packaged APC payment if billed on the same claim as HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." ● In other circumstances, laboratory tests should have a status indicator of "A" and payment is made under the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."*
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by

Indicator	Item, Code, or Service	OPPS Payment Status
		Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Reserved.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552.

(2) The cost-to-charge ratios are applied to each line-item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base year cost report.

2. The total calculated Medicaid cost for services listed at 441—paragraphs 78.31(1)*"g"* through *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding and then divided by the hospital-specific sum of relative discounted APC weights in the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—paragraphs 78.31(1)*"g"* through *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then divided by the sum of relative discounted APC weights in the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* will be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department will determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department will recover the difference.

(1) After any retrospective adjustment, the department will update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department will base these changes on the most recent utilization as submitted to the Iowa Medicaid and Medicare cost principles. Providers may be eligible for an "add-on" to the cost-to-charge ratio based on eligibility to participate in the annual Critical Access Hospital Cost Adjustment Factor Pool.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15 as amended to July 1, 2026, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552, Hospitals and Healthcare Complex Cost Report);

2. Either the Critical Access Hospital Supplemental Cost Report or the Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to Iowa Medicaid at the department's address.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department will update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates will be rebased. Cost reports used in rebasing will be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission timelines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code

crosswalk, to Iowa Medicaid by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices will be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund will be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program will be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs 79.1(16)*"k"*(1) and *"k"*(2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly and are available from the department.

(1) The hospital shall provide the Iowa Medicaid authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid, pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be implemented until federal financial participation to match money collected from the health care access assessment, pursuant to 441—Chapter 36, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when

a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement will be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Reserved.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room will be made pursuant to a fee schedule. Payment for treatment of a Medicaid member in an emergency room will be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room will be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the APC methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 and 447.325, both as amended to July 1, 2026. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Reserved.

u. Iowa Medicaid review. The department will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals.

v. Graduate medical education and disproportionate share fund. Payment will be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under

the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the sum of updated OPPS relative discounted APC weights, pursuant to paragraph 79.1(16)*"j,"* for the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to Iowa Medicaid for prior approval before the modification is initiated or the equipment is purchased. Payment will not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable will be based on the least expensive item that meets the member's medical needs.

c. Payment for most items will be based on a fee schedule and will conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee will be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee will be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m as amended to July 1, 2026), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee will be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price will be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price will be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment will be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment will not exceed 80 percent of the purchase allowance.

(8) No allowance will be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management (PCM) services reimbursement.* Pharmacist and PCM team members will be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member will be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments will be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventive follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services will be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services will be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee will be established for translation and interpretation services, which will be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026.

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in subrule 79.1(2), payments to rehabilitation agencies will be made as provided in the areawide fee schedule established for Medicare by the CMS as amended to July 1, 2026. The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association as amended to July 1, 2026. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims.* Subject to approval of a state plan amendment by CMS, payment for Medicare crossover claims will be made as follows.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicaid-allowed amount" means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicare-allowed amount" means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare cost sharing" means the Medicare member's responsibility to pay for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Medicare crossover claim" means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicare deductible and coinsurance amounts" means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare provider reimbursement" means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

"Third-party payment" means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims will be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) and **79.1(24)** Reserved.

79.1(25) *Reimbursement for community mental health centers (CMHCs).* CMHCs may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department. Once a CMHC chooses the alternative reimbursement rate methodology, the CMHC may not change its elected reimbursement methodology to 100 percent of reasonable costs.

a. Cost-based reimbursement. For CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following:

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, Iowa Medicaid will make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or

2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, Iowa Medicaid will make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that Iowa Medicaid will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by Iowa Medicaid. Iowa Medicaid will determine each provider's actual, allowable costs in accordance with generally accepted accounting

principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) Iowa Medicaid will make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) Iowa Medicaid will use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using a Financial and Statistical Report form. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552. The following requirements apply to all required cost reports:

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to July 1, 2026.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to Iowa Medicaid at the department's address. A provider that is not hospital-based shall submit a Financial and Statistical Report form on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both a Financial and Statistical Report form and CMS Form 2552 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to Iowa Medicaid. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, Iowa Medicaid will reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate will be paid for not longer than three months, after which time no further payments will be made.

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. Rate determination based on cost reports. Reimbursement will be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers will be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and Iowa Medicaid may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed will be subject to review or audit or both by Iowa Medicaid to determine the actual cost of services in accordance with generally accepted accounting principles, and Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, both as amended to July 1, 2026, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment will be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. Financial and statistical report submission and reporting requirements.

(1) The provider shall submit the complete Financial and Statistical Report form in an electronic format approved by the department to Iowa Medicaid within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to Iowa Medicaid. The extension request must be received by Iowa Medicaid before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to Iowa Medicaid in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to the email address on the form on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to Iowa Medicaid at the department's address no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)*"b"*(4), the department will reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) will be effective the first day of the sixth month following the provider's fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by Iowa Medicaid.

2. The reduced rate(s) will be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by Iowa Medicaid.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates will be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items that had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify Iowa Medicaid when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27)*"b."*

(2) For facilities that terminate activity with Iowa Medicaid, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless of if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27)*"a"* shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, Iowa Medicaid will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled will be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate will be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers will be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan starts to pay.

"Eligible member" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"Health insurance premium payment (HIPP) program" or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use a Health Insurance Premium Payment (HIPP) Provider Invoice form.

(1) Payment will be made to eligible providers for a HIPP program-eligible member's coinsurance, copayment, and deductible when the HIPP program-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1)*"c"* provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment as amended to July 1, 2026. The SIS assessment tool and scoring criteria are available on request from Iowa Medicaid.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30)*"f"* and *"g,"* are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30)*"g,"* acuity tiers are the highest applicable tier pursuant to the following:

(1) Tier 1: SIS activities score of 0 – 25.

(2) Tier 2: SIS activities score of 26 – 40.

(3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.

(4) Tier 4: SIS activities score of 45 or higher.

(5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.

(6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.

(7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.

(8) RBSCL tier: Members residing in a residential-based supported community living (RBSCL) facility.

(9) Enhanced tier: An individual member rate negotiated between the department and the provider.

g. The tier determined pursuant to paragraph 79.1(30)*"f"* shall be adjusted as follows:

(1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)*"e"*(1), but with a response of "extensive support needed" (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)*"e"*(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by two tiers.

(4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.

h. Tier redetermination. A member's acuity tier may be changed in the following circumstances:

(1) There is a change in the member's SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).

(2) A completed Emergency Needs Assessment form indicates a change in the member's support needs. A member's case manager may request an emergency needs assessment when a significant change in the member's needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member's acuity tier.

i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers, or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)*"c."*

441—79.2(249A) Sanctions.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

"Iowa Medicaid" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity that is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) *Grounds for sanctions.* The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include but are not limited to the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections, appeals, and licensing's Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act that is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or

accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.*

a. The department may impose any of the following sanctions on any person:

(1) A term of probation for participation in the medical assistance program.

(2) Termination from participation in the medical assistance program.

(3) Suspension from participation in the medical assistance program.

(4) Suspension of payments in whole or in part.

(5) Prior authorization of services.

(6) Review of claims prior to payment.

b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program will be retroactive to the date established by the CMS or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the department of justice, the department of inspections, appeals, and licensing, or a similar agency that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department will immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension will end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department will consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include but are not limited to:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of provider education (technical assistance).

f. Provider willingness to obey program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR §1002.212 as amended to July 1, 2026, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members as provided in 42 CFR §1001.2005 and 1001.2006, both as amended to July 1, 2026, whenever the department initiates an exclusion under 42 CFR §1002.210 as amended to July 1, 2026.

79.2(7) *Notice of violation.*

a. Any order of sanction will be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction will also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction will remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the department. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it will notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with Iowa Code section 249A.11 or 249A.47 are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance will the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under Iowa Code section 249A.39 must be made in writing, addressed to Iowa Medicaid, and contain all of the following:

(1) Person's name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) Claim number(s), as appropriate.

(6) Date(s) of service.

(7) Member identification number(s).

(8) National provider identification (NPI) number.

(9) Description of the corrective action plan to ensure the error does not occur again, if applicable.

(10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.

(11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Unless otherwise indicated below, the provider may document the services in any format so long as the documentation adequately substantiates the medical necessity and that the services were rendered. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"d,"* 441—paragraph 77.39(14)*"d,"* 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).

5. Medication administration record (MAR). The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service.

7. Narrative description of any incidents or illnesses or unusual or atypical occurrences that occur during service provision.

8. Any supplies dispensed as part of the service.

9. The first and last name and professional credentials, if any, of the person providing the service.

10. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

11. For 24-hour care, documentation for every shift of the services provided.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Other service documentation as applicable.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.
3. Other service documentation as applicable.

(9) Clinic services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.
2. Prenatal Risk Assessment form.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
7. Other service documentation as applicable.

(12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Prenatal Risk Assessment form.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Prenatal Risk Assessment form.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, or discharge summary).
2. Physician orders.

3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, or discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Case Activity Report form.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Case Activity Report form.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Resident Care Agreement form.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Case Activity Report form.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Case Activity Report form.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Election of Medicaid Hospice Benefit form.

3. Revocation of Medicaid Hospice Benefit form.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:

1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:

1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.
4. Other service documentation as applicable.

(25) Behavioral health intervention:

1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.
4. Other service documentation as applicable.

(26) Services provided by area education agencies and local education agencies:

1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:

1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician, nurse practitioner, physician assistant, or clinical nurse specialist orders or medical orders.

(28) Services provided by independent laboratories:

1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:

1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:

1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:

1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Notice of decision for service authorization.
2. Service notes or narratives.
3. Social history.
4. Comprehensive service plan.
5. Reassessment of member needs.
6. Incident reports in accordance with 441—subrule 24.4(5).
7. Other service documentation as applicable.

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. HCBS Attendant Care Agreement and Attendant Care Service Record.
8. Other service documentation as applicable.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing form.
2. Waiver of informed consent.
3. Prior authorization documentation.
4. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.
4. Other service documentation as applicable.

(40) Reserved.

(41) Services of public health agencies:

1. Service or office notes or narratives.
2. Immunization records.
3. Results of communicable disease testing.

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:

1. Department-approved standardized neurobehavioral assessment tool.
2. Community-based neurobehavioral treatment order.
3. Treatment plan.

4. Clinical records documenting diagnosis and treatment history.
5. Progress or status notes.
6. Service notes or narratives.
7. Procedure, laboratory, or test orders and results.
8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
9. Medication administration records.
10. Other service documentation as applicable.

(43) Child care medical services:

1. Plan of care.
2. Certification and recertification.
3. Service notes or narratives.
4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or Iowa Medicaid that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by Iowa Medicaid will include a Documentation Checklist form, which is available on the department's website, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, "good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit is considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size will be selected using accepted sample size estimation methods. The confidence level of the sample size calculation will not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by Iowa Medicaid, the request should be addressed to Iowa Medicaid at the department's address.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to the department at its address.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph 79.4(5)*"a"* may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department will issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal will not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) are not admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and federal regulations 45 CFR Part 84, both as amended to July 1, 2026, which prohibit discrimination on the basis of handicap in all federal Department of Health and Human Services funded programs.

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on an Agreement Between Provider of Medical and Health Services and the Iowa Department of Health and Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete an Addendum to Dental Provider Agreement for Orthodontia to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.*

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by the department. The initial ballot will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with department staff and the director, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership.* The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department.

(1) The length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2)*"a"*(3).

b. Council membership of public representatives shall consist of five representatives, of whom one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. Reserved.

d. Council membership shall also consist of state agency and medical school partners, including representatives from Des Moines University Medicine and Health Sciences and the University of Iowa Carver College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) *Responsibilities, duties and meetings.* The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department.

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department or the professional and business entities represented. The director will consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department. The department will arrange for a meeting place, related services, and accommodations. The department will provide staff support and independent technical assistance to the council.

a. The department will provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department will present the annual budget for the medical assistance program for review and comment.

c. The department will permit staff members to appear before the council to review and discuss specific information and problems.

d. The department will maintain a current list of members on the council.

e. The department will be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through an MCO. For services provided through an MCO, the prior authorization request is submitted, reviewed, and authorized by the MCO.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using an Outpatient Prior Authorization Request form, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to Iowa Medicaid. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use a Prior Authorization Attachment Control form as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on that form the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial of prescription drugs will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d) as amended to July 1, 2026.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in subrule 79.8(1).

79.8(7) Requests for prior approval of services will be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval will be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive covered procedures that would be as effective.

(5) The advice of an appropriate professional consultant.

b. When Iowa Medicaid has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) Iowa Medicaid will issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. Iowa Medicaid will mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by Iowa Medicaid, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service that would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)*"b,"* medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)*"a,"* medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by Iowa Medicaid as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact Iowa Medicaid to request approval of Medicaid coverage for the hospitalization according to instructions issued to providers by Iowa Medicaid and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if Iowa Medicaid denies the procedure requested in the preadmission review.

79.10(3) Iowa Medicaid will issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of

the decision by filing a written request with Iowa Medicaid within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

441—79.11(249A) Requests for preprocedure surgical review. Iowa Medicaid conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from Iowa Medicaid when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by Iowa Medicaid.

79.11(2) Iowa Medicaid will issue the physician a validation number for each request and advise whether payment for the procedure will be approved or denied.

79.11(3) Iowa Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, e.g., hospital or ambulatory surgical center, if Iowa Medicaid does not give approval.

79.11(4) Iowa Medicaid will issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with Iowa Medicaid within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid in accordance with 441—Chapter 7.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and an HMO at the time of enrollment of the person with the organization shall provide written information to each adult that explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law that allows for an objection on the basis of conscience for any provider or organization that as a matter of conscience cannot implement an advance directive.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid-enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Public Law 100-578, both as amended to July 1, 2026, and implementing federal regulations published at 42 CFR Part 493 as amended to July 1, 2026. Medicaid payment will not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with an MCO, shall begin the enrollment process by completing the appropriate application on the department's website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit a Medicaid HCBS Provider Application form at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit an Iowa Medicaid Ordering/Referring Provider Enrollment Application form.

c. All other providers shall submit an Iowa Medicaid Provider Enrollment Application form.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.11(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in rule 441—82.3(249A).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

g. Health insurance premium payment (HIPP) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to Iowa Medicaid at the department's address.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit an Assertive Community Services (ACS) Provider Agreement Addendum and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. Reserved.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C) as amended to July 1, 2026.

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under Iowa Code section 249A.48.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR §455.460 as amended to July 1, 2026.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to MCOs and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455 as amended to July 1, 2026. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)*"a"*(1), *"a"*(2), *"a"*(3), *"a"*(4), or *"a"*(5).

b. Iowa Medicaid may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7, but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. Iowa Medicaid will deny enrollment to or immediately disenroll any person that Iowa Medicaid, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and will deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)*"c."* Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the "limited," "moderate," or "high" categorical risk screening procedures and requirements in accordance with 42 CFR §455.450 as amended to July 1, 2026.

a. For the types of providers that are recognized as a provider under the Medicare program, Iowa Medicaid will use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518 as amended to July 1, 2026.

b. Provider types not assigned a screening level by the Medicare program will be subject to the procedures of the "limited" risk screening level pursuant to 42 CFR §455.450 as amended to July 1, 2026.

c. Adjustment of risk level. Iowa Medicaid will adjust the categorical risk screening procedures and requirements from "limited" or "moderate" to "high" when any of the following occurs:

(1) Iowa Medicaid imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state's Medicaid program; or

(2) Iowa Medicaid or CMS in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider will be notified of the decision on the provider's application within 30 calendar days of receipt by Iowa Medicaid of a complete and correct application with all required documents, including but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by Iowa Medicaid.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment will be made to a provider for care or services provided prior to the effective date of Iowa Medicaid's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided will be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to Iowa Medicaid and will be approved or denied within 30 calendar days. Approval of an amendment will be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by Iowa Medicaid. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform Iowa Medicaid of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include but are not limited to changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, Iowa Medicaid may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to Iowa Medicaid in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. Iowa Medicaid must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416 as amended to July 1, 2026.

79.14(15) Temporary moratoria. Iowa Medicaid must impose any temporary moratorium pursuant to Iowa Code section 249A.48.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed Iowa Medicaid while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, that provide detailed information about:

(1) The False Claims Act established under 31 U.S.C. Sections 3729 through 3733 as amended to July 1, 2026;

(2) Administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38 as amended to July 1, 2026;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs 79.15(1)*"a"*(1) through *"a"*(3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs as defined in 42 U.S.C. Section 1320a-7b(f) as amended to July 1, 2026; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to Iowa Medicaid by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to Iowa Medicaid at the department's address; or

(2) Faxing the information to 515.725.1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032, as amended to July 1, 2026.

441—79.16 Reserved.

441—79.17(249A) Requirements for prescribing controlled substances.

79.17(1) *Review of Iowa prescription monitoring program database.* A prescribing practitioner, as defined in Iowa Code section 124.550, or the prescribing practitioner's designated agent, shall review patient information in the Iowa prescription monitoring program (PMP) database prior to issuing a prescription for a controlled substance as defined in 42 U.S.C. 1396w–3a, inclusive of Schedules II, III and IV as amended to July 1, 2026, unless the patient is receiving inpatient hospice care or long-term residential facility care. Review shall be conducted in accordance with all requirements under the prescribing practitioner's specific professional licensing authority.

79.17(2) *Documentation.* The prescribing practitioner shall include documentation in the patient file to demonstrate compliance with subrule 79.17(1). Subject to the requirements under Iowa Code chapter 124, subchapter VI, if the prescribing practitioner is not able to conduct a review of the PMP database despite a good-faith effort, the prescribing practitioner must document in the patient file such good-faith effort, including the reasons why the prescribing practitioner was not able to conduct the review. The prescribing practitioner shall submit such documentation to Iowa Medicaid upon request.

This rule is intended to implement Iowa Code chapters 124 and 249A.

These rules are intended to implement Iowa Code chapter 249A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 80
"Procedure and Method of Payment"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking provides guidance on claim format and submission for providers of medical and remedial care that participate in Iowa's medical assistance program.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Health care providers participating in Iowa Medicaid will benefit from the guidance contained in this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

In SFY 2024, the Department received 14,758,588 claims and reimbursed $5,106,587,377.84 for services provided to covered Iowans.

- **Qualitative description of impact:**

This proposed rulemaking describes the specific requirements for submitting claims. Without this guidance, participating providers would not be able to be reimbursed properly for services provided to members.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement the proposed chapter.

- **Anticipated effect on State revenues:**

The proposed chapter has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required by law.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Rulemaking is required by law.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Rulemaking is required by law.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 80 and adopt the following **new** chapter in lieu thereof:

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT

441—80.1(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to Iowa Medicaid on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after the end of the calendar month in which the services are provided. Following audit of the claim, Iowa Medicaid will make payment to the provider of care. The provider manual, Chapter IV, Billing Iowa Medicaid, found on the department's website and as amended to July 1, 2026, will detail the specific manner and frequency in which claims are to be submitted.

80.1(1) Electronic submission. Providers are required to submit claims electronically whenever possible.

80.1(2) For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to Iowa Medicaid must submit the following electronically, in accordance with the All Providers manual, Chapter IV, Billing Iowa Medicaid, located on the department's website and as amended to July 1, 2026:

a. Form UB-04.

b. Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by Iowa Medicaid.

441—80.2(249A) Payment from other sources. This rule applies to claims for the department, managed care organizations, and the Public Health Associate Program (PHAP).

80.2(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source will be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.2(2) *Third-party liability.*

a. When a third-party liability for medical expenses exists, this resource will be utilized for payment of a claim before the Medicaid program makes payment unless:

(1) The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

1. Preventive pediatric services, and
2. All services provided to a person for whom there is court-ordered medical support.

(2) Otherwise authorized by the department.

b. All claims must be clean claims. A clean claim is defined as 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.

80.2(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. No later than 60 days after receiving any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service, respond to such inquiry, pursuant to 42 U.S.C. Section 1396a(25)(I)(iii) as amended to July 1, 2026.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point of sale that is the basis of the claim, or, in the case of a responsible third party (other than the original Medicare fee-for-service program under Parts A and B of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a Medicare Advantage plan offered by a Medicare Advantage organization under Part C of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a reasonable cost of reimbursement plan under 42 U.S.C. Section 1395mm as amended to July 1, 2026, a health care prepayment plan under 42 U.S.C. Section 1395l as amended to July 1, 2026, or a prescription drug plan (PDP) offered by a PDP sponsor under Part D of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026), a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

d. Agree not to deny any claim submitted by the state solely because of lack of prior authorization.

441—80.3(249A) Time limit for submission of claims and claim adjustments.

80.3(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by Iowa Medicaid exceeds 365 days. The department will consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.3(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by Iowa Medicaid within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.3(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

441—80.4(249A) Authorization process.

80.4(1) *Identification cards.* The department will issue a medical assistance eligibility card to members for use in securing medical and health services available under the program except as provided in 441—Chapter 76.

a. The department will issue the medical assistance eligibility card:

(1) When the member's eligibility is initially determined.

(2) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The medical assistance eligibility card is valid only for months in which the member has established eligibility as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.4(2) Reserved.

441—80.5(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below.

80.5(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with 441—Chapter 75.

80.5(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.5(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

441—80.6(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406 as amended to July 1, 2026), service benefit plans, managed care organizations, pharmacy benefits managers, and other

parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.6(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. A data use agreement shall prescribe the specific detail elements required, any privacy protections, the manner in which information shall be provided to the department or its designee, and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department or its designee to match covered persons and identify third-party payors for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.6(2) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended to July 1, 2026; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164 as amended to July 1, 2026.

These rules are intended to implement Iowa Code chapter 249A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 83
"Medicaid Waiver Services"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A; 2005 Iowa Acts, chapter 167, section 13; and 2005 Iowa Acts, chapter 117, section 3

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed chapter is to describe and outline the provision of services under the Medicaid waiver program. Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients since the services are beyond the scope of the Medicaid State plan.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of its review, the Department deleted redundant, restrictive, and outdated language and added dates certain.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Iowans eligible for or receiving services under one of Iowa's Medicaid waiver programs will benefit from this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

There are almost 30,000 Iowans receiving medical services provided under Iowa's Medicaid waiver programs.

- **Qualitative description of impact:**

The almost 30,000 Iowans receiving medical services provided under Iowa's Medicaid waiver programs may not otherwise be able to receive medical services without the waiver programs.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

The proposed rulemaking has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is both appropriate and required by law.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 83 and adopt the following **new** chapter in lieu thereof:

CHAPTER 83
MEDICAID WAIVER SERVICES

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

"Blind" means an individual has a central visual acuity of 20/200 or less in the better eye with the use of a corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled" means an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Guardian" means a guardian appointed in probate court.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for persons with an intellectual disability that has been approved as a Medicaid vendor.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Member" means an individual who has been determined to be eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, the member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Substantial gainful activity" means productive activities that add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payment" means payment from an attorney, individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026.

b. Reserved.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC and the interRAI - HC are available upon request from Iowa Medicaid. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1)*"b."*

(2) Iowa Medicaid will be responsible for the initial determination of the member's level of care certification. Iowa Medicaid or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. Iowa Medicaid will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2)*"b"* and 75.82(4)*"c"* will be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department that is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager will establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan will be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)*"d"* and other supporting documentation as relevant. The designated case manager will have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services will not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/ID
$3,014.69	$1,035.79	$4,040.52

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) will be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget will be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted MCO during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department will determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services will become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget will extend up to the first of the month following the member's twenty-fifth birthday and will remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search will be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month

period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver will be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name will be placed on a waiting list maintained by Iowa Medicaid.

a. The department field office will enter all waiver applications into the institutional and waiver service and narrative system (IoWANS) to determine whether a payment slot is available.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health coverage and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot will be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the department field office will give written notice to the applicant. The department will hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department will enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed application for health coverage and help paying costs is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date a request as specified in subparagraph 83.3(2)*"a"*(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots will have their application rejected, and their names will be maintained on the waiting list. They will be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. Iowa Medicaid will contact the department field office when a slot becomes available.

(5) Once a payment slot is assigned, the department field office will give written notice to the person within five working days. The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The department field office will notify Iowa Medicaid within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information that is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to Iowa Medicaid.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application will be denied.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility will be effective on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)*"a"* and *"c"* do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)*"c"*(3) will exist on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid will make no payments to health and disability waiver service providers. However, Medicaid will make payments to other medical vendors, as applicable.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.17(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.5(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1)*"b."* Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers that will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in paragraph 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in paragraph 83.2(2)*"b."*

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the designated case manager.

e. Service providers are not available.

83.8(3) Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.9(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

441—83.10 to **83.20** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Guardian" means a guardian appointed in probate court.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility that has been approved as a Medicaid vendor.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2)*"b"* and 75.82(4)*"c"* will be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - HC is available on request from the department and other supporting documentation as relevant. Copies of the completed interRAI - HC for an individual are available to that individual from the individual's case manager or MCO.

(1) The assessment will be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care. The department will be responsible for determination of the initial level of care.

(2) The department or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. Case management. Members under the elderly waiver will receive case management services from a provider qualified pursuant to rule 441—77.38(249A). Case management services will be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Interdisciplinary team. The case manager will establish an interdisciplinary team for the member.

(1) Composition. The interdisciplinary team will include the case manager and the member and, if appropriate, the member's legal representative, family, service providers, and others directly involved in the member's care.

(2) Role. The team will identify:

1. The member's need for services based on the member's needs and desires.
2. Available and appropriate services to meet the member's needs.
3. Health and safety issues for the member that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change.

c. Service plan. An applicant for elderly waiver services will have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan will be appropriate to the problems and specific needs or disabilities of the member.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the member's needs.

d. Content of service plan. The service plan will include the following information based on the member's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the member received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the member is to receive.

(9) Indication of whether the member has elected the consumer choice option and, if so, the independent support broker and the financial management service that the member has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the member in situations for which no approved service plan exists and that, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage. Emergency plans will include:

1. The member's risk assessment and the health and safety issues identified by the member's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.23(2) *Approval of application.*

a. Applications for the elderly waiver program will be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision will be made as soon as possible.

b. Decisions will be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in paragraph 83.22(1)*"d,"* indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(3) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines will not exist until the persons require care in a medical institution for a period of 30 consecutive days and will be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum supplemental security income (SSI) grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services will be done at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination will contain the components listed in rule 441—83.27(249A).

83.25(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.25(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan will be completed jointly by the member, the elderly waiver case manager, and any other person identified by the member.

83.27(1) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.27(2) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs are not met by services provided.

d. Needed services are not available or received from qualifying providers.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.

c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

d. Service providers are not available.

83.28(3) Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 7.

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management will cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services will be used.

441—83.31 to **83.40** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Guardian" means a guardian appointed in probate court.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility or hospital that has been approved as a Medicaid vendor.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an attorney, individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The assessment as listed in paragraph 83.42(1)*"b"* will be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

(2) The department will be responsible for approval of the certification of the level of care, and the department or an MCO will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services will not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income that does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The designated case manager will review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review will be based, in part, on information in the completed information submission tool designated in paragraph 83.42(1)*"b"* and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services will not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $2,026.03.

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.43(2) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, that is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the department.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the member service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(3) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—paragraph 75.6(4)*"b"* and rule 441—75.82(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive

days for other than respite care will be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

83.43(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under SSI from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services will be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors will be made in accordance with rules 441—76.17(249A) and 441—83.42(249A). A redetermination will include the components listed in rule 441—83.47(249A).

83.45(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.45(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan will be prepared for AIDS/HIV waiver members in accordance with rule 441—130.7(234) except that service plans for both children and adults will be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan will include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.47(3) Service plans for members aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in paragraph 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in paragraph 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action shall be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 7.

441—83.50 to **83.59** Reserved.

These rules are intended to implement Iowa Code section 249A.4.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with an intellectual disability aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

"Child" means a person with an intellectual disability aged 17 or under.

"Client participation" means the posteligibility amount of the member's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the member and caregiver by a QIDP to facilitate home management of the member and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Direct service" means services involving face-to-face assistance to a member such as transporting a member or providing therapy.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) that will be made only when the onset of the person's condition was during the developmental period and will be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the DSM.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Organization" means the entity being certified.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified intellectual disability professional" or *"QIDP"* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the Academy of Nutrition and Dietetics.

10. A human services professional who must have at least a bachelor's degree in a human services field, including but not limited to sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"SIS assessment" means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payment" means payment from an attorney, individual, institution, corporation, insurance company, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The department will be responsible for the initial approval, and the department or an MCO will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a member must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the department. Requests for approval shall be submitted in writing to the department and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(15), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of the information submission tool for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or case manager:

(1) Arrange for completion of the information submission tool for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager will be referred to a Medicaid case manager.

d. Services will not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests will only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of an information assessment tool for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager will establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager will complete an annual review thereafter. The following criteria will be used for the initial and ongoing identification of need for services:

(1) The assessment will be based on the results of the most recent information assessment tool for children under the age of five and, for all others, the SIS assessment or the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under which include supported community living services beyond intermittent will be approved (signed and dated) by the department. The service worker, department QIDP, or Medicaid case manager will attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance will provide a rationale for requesting supported community living beyond intermittent. The rationale will contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state will be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department will make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots will be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list will be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department will determine whether a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot will be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department will give written notice to the applicant.

(2) The department will hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant will be placed on a statewide priority waiting list. The department will assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)*"b"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.61(4)*"b"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons will be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

d. The state reserves payment slots each waiver year (July 1 to June 30) for use by children who must reside outside the family home in a residential-based supported community living licensed residential care facility. The state also reserves payment slots each waiver year (July 1 to June 30) for use by members living in an ICF/ID, nursing facility, or out-of-state placement, or transitioning from the Money Follows the Person Grant, who choose to access services in the intellectual disability waiver program and leave the ICF/ID, nursing facility, or out-of-state placement to live in the community.

(1) Applicants who currently reside in an ICF/ID or nursing facility and have resided in that setting for four or more months may request a reserved capacity slot through the intellectual disability waiver.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have the person's name maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on the person's order on the waiting list.

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.62(2) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program will be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision will be made as soon as possible.

b. Decisions will be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant will be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker will have the member or legal representative indicate the member's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved will not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a member of group foster care services or is an inpatient in a medical institution will not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(3) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

d. Eligibility continues until the member fails to meet eligibility criteria listed in rule 441—83.61(249A). Members who are inpatients in a medical institution for 120 consecutive days will receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Members will be reviewed for eligibility under other Medicaid coverage groups. The member or legal representative will participate in the review and receive formal notification of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services will be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. An information assessment tool will be completed annually for children under the age of five. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.64(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.65 Reserved.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

441—83.67(249A) Service plan. A service plan will be prepared for each HCBS intellectual disability waiver member.

83.67(1) *Development.* The service plan will be developed by the interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan will be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting will be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member at the time of waiver program enrollment.

b. For supported community living:

(1) The member's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the member.

(3) The number of other waiver members who will live with the member in the living unit.

c. An identification and justification of any restriction of the member's rights, including but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

f. The amount of the service to be received by the member.

g. Whether the member has elected the consumer choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

h. A plan for emergencies and identification of the supports available to the member in an emergency.

i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

(1) Score on subsection 1A: Exceptional Medical Support Needs.

(2) Score on subsection 1B: Exceptional Behavioral Support Needs.

(3) Sum total of standard scores on the following subsections:

1. Subsection 2A: Home Living Activities;
2. Subsection 2B: Community Living Activities;
3. Subsection 2E: Health and Safety Activities; and
4. Subsection 2F: Social Activities.

83.67(5) *Documentation.* The Medicaid case manager will ensure that the member's case file contains the member's service plan and documentation supporting the diagnosis of intellectual disability.

83.67(6) *Approval of plan.* The plan will be approved through the institutional and waiver authorization and narrative system (IoWANS). Services shall be entered into IoWANS based on the service plan.

a. Services must be authorized and entered into IoWANS before the plan implementation date.

b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within ten days, the department has final authority regarding the services and service cost.

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3)*"a"* or *"b"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"d," "g,"* or *"h"* apply.

b. Needed services are not available or received from qualifying providers.

c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program member has not occurred.

g. The member receives services from other Medicaid waiver programs.

h. The member or legal representative through the interdisciplinary process requests termination from the services.

441—83.69(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 7.

441—83.70(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. More information can be found in 265—Chapter 24.

441—83.71 to **83.80** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires and goals.

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, that temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the member's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Direct service" means services involving face-to-face assistance to a member such as transporting a member or providing therapy.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Organization" means the entity being certified.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

"Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payment" means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a member must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Reserved.

f. Be determined by the department as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC and the MPAI are available on request from the member's MCO or the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

g. Be assessed by the department as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

p. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

a. The applicant will have a service plan approved by the department that is developed by the Medicaid case manager for this waiver. This must be completed before services provision and annually thereafter. The case manager will establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the department.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state plan services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the department's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month

period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The member shall access, if a child, all other services for which the person is eligible and that are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *Securing a state payment slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed services application or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department will enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an ICF/ID, a skilled nursing facility, or an ICF and have resided in that setting for four or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department will reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state. Applicants may request an emergency need reserved capacity slot by submitting the completed home- and community-based services (HCBS) brain injury waiver emergency need assessment to the department.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(3)*"e"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.82(3)*"e"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will remain on the waiting list, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the department and request that a new emergency needs assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the member to have all medically necessary service needs met within the scope of this waiver will be initiated on behalf of the member and with the member's consent or with the consent of the member's legal representative by the discharge planner of the medical facility where the member resides at the time of application or the case manager. The discharge planner or case manager will provide to the department all appropriate information needed regarding all the medically necessary service needs of the member. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the department will inform the discharge planner or case manager on behalf of the member or the member's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the member's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver will be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions will be mailed or given to the member or the member's legal representative on the date when each eligibility determination is completed.

c. An applicant will be given the choice between waiver services and institutional care. The applicant or legal representative will sign the applicable information submission tool listed in paragraph 83.82(1)*"f,"* indicating that the applicant has elected home- and community-based services. This will be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, will contact the member's MCO or the designated case manager to initiate development of the member's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager will establish an HCBS BI waiver interdisciplinary team for each member and, with the team, identify the member's "need for service" based on the member's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in rule 441—83.82(249A). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by the department to determine additional inpatient needs for possible termination from the brain injury waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver member meets the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

441—83.84(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4)*"b"* (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the member that is 300 percent of the maximum SSI grant for an individual from the member's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination will contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, member-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan will be prepared and utilized for each HCBS BI waiver member. The service plan will be developed by an interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager, providers, and others directly involved. The service plan will be stored by the case manager for a minimum of three years. The service plan staffing will be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member at the time of waiver program enrollment.

b. For supported community living:

(1) The member's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the member.

(3) The number of other waiver members who will live with the member in the living unit.

c. An identification and justification of any restriction of a member's rights, including but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the member.

g. Whether the member has elected the member choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

h. A plan for emergencies and identification of the supports available to the member in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager will attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The department will assess the member annually and certify the member's need for long-term care services. The department will be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1)*"f"* and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) *Service file.* The Medicaid case manager must ensure that the member service file contains the member's service plan.

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The member is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the member's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.

g. The member receives services from other Medicaid waiver providers.

h. The member or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3)*"a"* or *"b"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"d," "g,"* or *"h"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service member has not occurred.

g. The member receives services from other Medicaid providers.

h. The member or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

441—83.90 to **83.100** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires and goals.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Client participation" means the amount of the member's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Guardian" means a guardian appointed in probate court for an adult.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the DSM or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a member must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026, or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the member.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Reserved.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - PEDS-HC and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) Initial decisions on level of care will be made for the department by the department within two working days of receipt of medical information. Iowa Medicaid determines whether the level of

care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant will have a service plan that is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager will identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in paragraph 83.102(1)*"h,"* as well as the availability and appropriateness of services.

(2) The service worker will have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, will not exceed $761.95 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state will be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots will be available on a first-come, first-served basis.

83.102(4) *Securing a slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health services and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department will enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants will be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie will be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(5) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list will be sent to the person by the department.

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver will be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner will contact the member's MCO or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h."*

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the discharge planner of the decision.

b. Applications for this waiver will be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's MCO or the designated case manager will arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and submit it to the department.

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver will be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions will be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant will be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care will sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care will cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The member may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in subrule 83.102(1). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by Iowa Medicaid to determine additional inpatient needs for possible termination from the physical disability waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver member meets the institutional level of care requirement as determined by the department or an appeal decision will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for a prior institutionalization will be applied to the waiver application.

441—83.104(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4)*"b"* (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation will be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum supplemental security income (SSI) grant for an individual from the member's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination will contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are member-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan will be prepared and used for each HCBS physical disability waiver member. The service plan will be developed and approved by the member, the member's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the member.

e. Whether the member has elected the member choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

f. A plan for emergencies and identification of the supports available to the member in an emergency.

83.107(2) *Annual assessment.* The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process in rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the member's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.

g. The member receives services from other Medicaid waiver providers.

h. The member or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3)*"a"* or *"b"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"d," "g,"* or *"h"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the member for the physical disability waiver service has not occurred.

g. The member receives services from other Medicaid providers.

h. The member or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

441—83.110 to **83.120** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, abilities, desires, and goals.

"Case manager" means the person designated to provide Medicaid targeted case management services for the member.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Deeming" means considering parental or spousal income or resources as income or resources of a member in determining eligibility for a member according to Supplemental Security Income program guidelines.

"Guardian" means a parent of a member or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME QIO" means the entity contracted with the department that determines the level of care for members initially applying for or continuing to receive children's mental health waiver services.

"Interdisciplinary team" means the member, the member's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the member's needs, as designated by the member and the member's family, who meet to develop a service plan based on the individualized needs of the member.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" or *"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" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Member" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in rule 441—75.1(249A) and is a recipient of children's mental health waiver services.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Psychiatric medical institution for children level of care" means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.10(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the DSM and (2) has resulted in a functional impairment that substantially interferes with or limits a member's role or functioning in family, school, or community activities. "Serious emotional disturbance" does not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team that includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for members eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a member must meet all of the following requirements:

83.122(1) *Age.* The member must be under 18 years of age.

83.122(2) *Diagnosis.* The member must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The department or an MCO will certify the applicant's level of care annually based on information submitted on a case management comprehensive assessment for children aged 3 and under or on the interRAI - child and youth mental health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - adolescent supplement will also be completed in addition to the interRAI - ChYMH. The interRAI - ChYMH and the interRAI - adolescent supplement are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

83.122(4) *Financial eligibility.* The member must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under a supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) *Need for service.* The member must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.127(249A).

a. The member must be a recipient of case management or be identified to receive case management immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed $2,165.87 per month.

c. At a minimum, each member must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A member may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A member may be enrolled in only one HCBS waiver program at a time.

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of members specified in the approved waiver, the member's application will be rejected and the member's name shall be placed on a waiting list.

a. The local office will determine whether a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed application for health services or help paying costs from a member who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office will enter the application into institutional and waiver authorization and narrative system (IoWANS) to begin the waiver approval process.

(1) The department will hold the payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next member on the waiting list, if applicable. The member must reapply for a new slot.

c. If no payment slot is available, the department will enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed application for health services or help paying costs is received by the department;

(2) The names of Medicaid members will be added to the waiting list on the date as specified in paragraph 83.123(1)*"a."*

(3) In the event that more than one application is received at one time, the names of members will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Members whose names are on the waiting list will be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved members on the program is maintained.

(1) Once a payment slot is assigned, the department will give written notice to the member within five working days.

(2) The department will hold the payment slot for 30 days for the member to file a new application.

(3) If an application has not been filed within 30 days, the slot will revert for use by the next member on the waiting list, if applicable. The member originally assigned the slot must reapply for a new slot.

e. The state reserves payment slots each waiver year (October 1 to September 30) for use by members living in a state of Iowa mental health institute (MHI), a psychiatric residential treatment facility (PRTF), or an out-of-state facility placement who choose to access services in the children's mental health waiver program and leave the MHI, PRTF, or out-of-state placement to live within their family home. For the purpose of reserved capacity within the children's mental health waiver program, an MHI is defined in Iowa Code section 226.1 and a PRTF is defined in 42 CFR 483.352.

(1) Applicants who currently reside in an MHI, PRTF, or out-of-state placement and have resided in that setting for four or more months may request a reserved capacity slot through the children's mental health waiver program.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children's mental health waiver program will be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal SSI benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the member or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application will be denied.

b. Notice of decisions. The department will mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) *Effective date of eligibility.* The effective date of a member's eligibility for children's mental health waiver services will be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

441—83.124(249A) Financial participation. A member must contribute to the cost of children's mental health waiver services to the extent of the member's total income less 300 percent of the maximum monthly payment for one person under the federal SSI program.

441—83.125(249A) Redetermination. The department will redetermine a member's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the member's situation or condition.

83.125(1) *Eligibility review.*

a. Every 12 months, the department will review a member's eligibility in accordance with procedures in rule 441—76.17(249A). The review will verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process in rule 441—83.129(249A), based on the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

c. The department or the member's MCO will be responsible for annual redetermination of the level of care.

d. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) *Continuation of eligibility.* A member's waiver eligibility will continue until one of the following conditions occurs.

a. The member fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The member is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the member has spent 120 consecutive days in a medical institution, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

(2) If the member returns home after 120 consecutive days, the member must reapply for children's mental health waiver services, and Iowa Medicaid must redetermine the member's level of care.

c. The member does not reside at the member's natural home for a period of 60 consecutive days. After the member has resided outside the home for 60 consecutive days, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

83.125(3) *Payment slot.* When a member loses waiver eligibility, the member's assigned payment slot will revert for use to the next member on the waiting list.

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver will be provided as set forth in rule 441—78.52(249A) and will include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The member's case manager will prepare an individualized service plan for each member that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan will be developed through an interdisciplinary team process.

83.127(2) The service plan will be developed annually or when there is significant change in the member's situation or condition.

83.127(3) The service plan will be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan will specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan will identify and justify any restriction of the member's rights.

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services will be denied when the department determines that:

a. The member is not eligible for or in need of waiver services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the limit on aggregate monthly costs established in paragraph 83.122(6)*"b"* or are not met by the services provided.

83.128(2) *Termination.* A member's participation in the children's mental health waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the children's mental health waiver services for the member exceed the aggregate monthly costs established in paragraph 83.122(6)*"b."*

c. The member receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.

d. The physical or mental condition of the member requires more care than can be provided in the member's own home, as determined by the member's case manager.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.129(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 7.

These rules are intended to implement Iowa Code section 249A.4 and chapter 249J.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 90
"Fee-for-Service Case Management"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking is being undertaken pursuant to Executive Order 10. This proposed chapter describes case management services provided to members covered under the medical assistance fee-for-service (FFS) program. Some Iowa Medicaid members are served through an FFS system where their health care providers are paid separately for each service (like an office visit, test, or procedure). This includes members who qualify for or receive services from the following FFS programs:

- Health Insurance Premium Payment Program (HIPP)
- Medicare Savings Program (MSP)
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Emergency Medical Services
- Medically Needy (also known as the spenddown program)
- Presumptive Eligibility (subject to change once ongoing eligibility is determined)

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of its review, the Department eliminated duplicative, outdated, and redundant terminology; added dates certain; and renamed the chapter to clarify that it is applicable to FFS Medicaid members.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Individuals covered under the FFS medical assistance program who are eligible for case management services will benefit from this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

There are 43,244 individuals enrolled in FFS Medicaid.

- **Qualitative description of impact:**

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

This proposed rulemaking has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

This proposed rulemaking is required by law and necessary for efficient administration of the case management program.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 90 and adopt the following **new** chapter in lieu thereof:

CHAPTER 90
FEE-FOR-SERVICE CASE MANAGEMENT

441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Applicant" means a person who has applied for an HCBS waiver or habilitation program.

"Case management" means the categories of case management: targeted case management (TCM) and case management provided to members enrolled in a 1915(c) waiver.

"Case manager" means the staff person providing the case management services regardless of the entity providing the service.

"Child" means a person other than an adult.

"Chronic mental illness" means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found in 441—Chapter 24. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Core standardized assessment" or *"CSA"* means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant's or member's needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs.

"Developmental disability" means a severe, chronic disability that is determined through professionally administered screening and evaluations.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act as amended to July 1, 2026.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in 441—Chapter 83.

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in numbered paragraph "1," "2," or "3"; or
7. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"Managed care organization" or *"MCO"* means the same as defined in 441—Chapter 73.

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 CFR Section 435.1009 as amended to October 20, 2022.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that is not a major incident but that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

"Targeted case management" or *"TCM"* means case management services furnished to assist members who are part of a targeted population.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or
2. A child who is eligible to receive HCBS waiver services according to 441—Chapter 83.

A member enrolled with an MCO is not part of the targeted population.

441—90.2(249A) Targeted case management. Rule 441—90.2(249A) applies only to the case management category of TCM and the defined targeted population.

90.2(1) *Eligibility for targeted case management.* A person who meets all of the following criteria will be eligible for TCM:

a. The person is eligible for Medicaid or is conditionally eligible under 441—Chapter 75;

b. The person is a member of a targeted population;

c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);

d. The person has applied for TCM in accordance with the policies of the provider;

e. The person is not eligible for or enrolled in an MCO.

90.2(2) *Determination of need for targeted case management.* Assessment at least every 365 days since the date of identified need for TCM is required as a condition of eligibility under the medical assistance program. The TCM provider manual found on the department's website and as amended to July 1, 2026, contains more information.

90.2(3) *Application for targeted case management.* The TCM provider shall process a received application for TCM no later than 30 days after receipt of the application. The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, has more information.

90.2(4) *Transition to a community setting.* The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, contains information about services that may be provided to a member transitioning to a community setting.

441—90.3(249A) Termination of targeted case management services. TCM shall be terminated only under the specific circumstances detailed in the Medicaid manual for TCM available on the department's website and as amended to July 1, 2026.

441—90.4(249A) Case management services. Rule 441—90.4(249A) applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in FFS case management services provided to members:

a. Assessment. Initial assessments and regular reassessments must be completed for each member to determine the need for medical, social, educational, housing, transportation, vocational, or other services, as specified in the Medicaid manual for TCM available on the department's website and as amended through July 1, 2026.

b. Person-centered service plan. The case manager shall develop and revise a comprehensive, person-centered service plan at least every 365 days in accordance with the Medicaid manual for case management found on the department's website and as amended to July 1, 2026.

c. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member.

d. Contacts. The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly. The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone.

90.4(2) *Exclusions.* Payment will not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred.

c. The activities are components of the administration of foster care programs.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act as amended to August 1, 2025.

e. The activities duplicate institutional discharge planning.

441—90.5(249A) Rights restrictions. Rule 441—90.5(249A) applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member, or the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. For more information, refer to the Person Centered Service Plan manual as amended to July 1, 2026, available on the department's website.

441—90.6(249A) Documentation and billing. Documentation of contacts. Subrule 90.6(1) applies to all categories of case management and all populations covered by case management. The case management billing manual for case management contact documentation and billing requirements available on the department's website and as amended to July 1, 2026, contains more information.

441—90.7(249A) Case management services provider requirements.

90.7(1) Rule 441—90.7(249A) applies to all categories of case management and all populations covered by case management. Major or minor incidents shall be reported according to the case management incident reporting manual available on the department's website and as amended to July 1, 2026.

90.7(2) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by Iowa Medicaid, as well as any other state or federal entity with

oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include but are not limited to:

a. Postpayment review of case management services;
b. Review of incident reports;
c. Review of reports of abuse or neglect; and
d. Technical assistance in determining the need for service.

These rules are intended to implement Iowa Code section 249A.4.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapters 105, 106, 114, and 115
"Protective Locked Environment for Certain Children"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 237C and 2025 Iowa Acts, House File 474

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 237C and 2025 Iowa Acts, House File 474

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking adds clarification to existing rules and implements 2025 Iowa Acts, Senate File 474, sections 33 through 37, regarding a protected locked environment for certain children. Proposed references to Iowa Code section 237.1(8A) are to that section as enacted by Senate File 474.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There is no cost to the proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

This proposed rulemaking will benefit children who, for their own safety, need to be kept in a protective locked environment as a part of their ongoing treatment and care.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Not applicable.

- **Qualitative description of impact:**

This proposed rulemaking will benefit children who, for their own safety, need to be kept in a protective locked environment as a part of their ongoing treatment and care.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

There are no additional enforcement costs to implement this proposed rulemaking.

- **Anticipated effect on State revenues:**

This proposed rulemaking is not expected to affect State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

The proposed rulemaking is required by 2025 Iowa Acts, Senate File 474, sections 33 through 37.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable. The proposed rulemaking is required by 2025 Iowa Acts, Senate File 474, sections 33 through 37.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

The proposed rulemaking is required by 2025 Iowa Acts, Senate File 474, sections 33 through 37.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking is not expected to have an impact on small business.

Text of Proposed Rulemaking

ITEM 1. Adopt the following **new** definition of "Protective locked environment" in rule **441—105.1(232)**:

"Protective locked environment" means the same as defined in Iowa Code section 237.1(8A).

ITEM 2. Adopt the following **new** paragraph **105.8(10)"g"**:

g. Defining protective locked environment and how it is utilized to provide safety and security for children.

ITEM 3. Adopt the following **new** definition of "Protective locked environment," in rule **441—106.1(237C)**:

"Protective locked environment" means the same as defined in Iowa Code section 237.1(8A).

ITEM 4. Adopt the following **new** definition of "Protective locked environment," in rule **441—114.2(237)**:

"Protective locked environment" means the same as defined in Iowa Code section 237.1(8A).

ITEM 5. Adopt the following **new** definition of "Protective locked environment," in rule **441—115.2(237)**:

"Protective locked environment" means the same as defined in Iowa Code section 237.1(8A).

ITEM 6. Rescind the definition of "Nonsecure facility" in rule **441—115.2(237)**.

ITEM 7. Amend subrule 115.6(1) as follows:

115.6(1) ~~*Nonsecure*~~ *Protective locked environment facilities.* Physical restraints and a control room are permitted in ~~nonsecure~~ protective locked environment facilities.

ITEM 8. Amend subrule 115.6(3) as follows:

115.6(3) *Written policies.* A facility ~~which~~ that uses restraints shall have a written policy on their use. This policy shall include:

a. and *b.* No change.

c. Identification of staff or licensed professionals authorized to approve and use each form of restraint.

d. to *f.* No change.

ITEM 9. Amend paragraph **115.6(4)"b"** as follows:

b. A facility shall not use restraint as a disciplinary or punitive measure, for staff convenience, as a preventive measure, or as a substitute for programming.

ITEM 10. Amend paragraph **115.6(4)"d"** as follows:

d. A secure facility shall continually review any use of a restraint on a child, other than physical restraint. ~~The facility shall release the child from restraint immediately when the situation precipitating restraint no longer exists.~~

ITEM 11. Adopt the following **new** paragraph **115.6(4)"e"**:

e. A facility shall release the child from restraint immediately when the situation precipitating restraint no longer exists.

ITEM 12. Amend paragraph **115.7(4)"g"** as follows:

g. The child shall remain in the control room longer than one hour only with consultation and approval from the ~~supervisor~~ authorized staff or licensed professional. Documentation in the child's case record shall include the time in the control room, the reasons for the control, and the reasons for the extension of time. Use of the control room for a total of more than 12 hours in any 24-hour period shall occur only after authorization of the psychiatrist or upon court order. In no case shall a child be in a control room for a period longer than 24 hours.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 125
"Kinship Foster Care Approval Standards"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 237 and 2025 Iowa Acts, Senate File 641

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 237 and 2025 Iowa Acts, Senate File 641

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter implements 2025 Iowa Acts, Senate File 641, by establishing approval standards for individuals seeking to be approved for Kinship Foster Care.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There is no expected cost to this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Fictive kin who are seeking to become approved foster care providers and children with fictive kin will benefit from clear rules regarding the approval standards for Kinship Foster Care providers.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Since going into effect on July 1, 2025, the provisions of 2025 Iowa Acts, Senate File 641, have allowed approximately 150 Kinship Foster Care approvals.

- **Qualitative description of impact:**

Since the implementation of 2025 Iowa Acts, Senate File 641, many additional Kinship Caregivers have been referred to the program and are currently in the process of completing the approval process.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

No additional costs are expected to be borne by the agency to implement this proposed rulemaking.

- **Anticipated effect on State revenues:**

No effect on State revenues is expected.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

This proposed rulemaking is required by 2025 Iowa Acts, Senate File 641.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

This proposed rulemaking is required by 2025 Iowa Acts, Senate File 641.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking is not expected to have an impact on small business.

Text of Proposed Rulemaking

ITEM 1. Adopt the following **new** 441—Chapter 125:

CHAPTER 125
KINSHIP FOSTER CARE APPROVAL STANDARDS

441—125.1(237) Definitions.

"Approval" means the authorization granted to a kinship caregiver by the department through an expedited process to provide child foster care and allows the kinship caregiver to receive maximum financial support and to obtain the information and resources necessary to meet the needs of a child under a court-ordered placement with the kinship caregiver.

"Approved kinship caregiver" means a kinship caregiver granted approval for kinship foster care.

"Child," for the purpose of this chapter, only means the child or children who are in foster care.

"Consanguinity" means relatives who share a common biological ancestor with the child.

"Corporal punishment" means the intentional physical punishment of children.

"Fictive kin" means an adult person who is not a relative of a child but who has an emotionally significant and positive relationship with a child or the child's family.

"Kinship care" means the care of a child by a relative or fictive kin providing full-time nurturing and protection.

"Kinship foster care" means an expedited process to approve a kinship caregiver for foster care through providing the necessary information, resources, and maximum financial support to the caregiver to meet the needs of the child court ordered to placement in the caregiver's care.

"Kinship foster caregiver" means a relative or fictive kin providing care for a child who is approved for kinship foster care.

"Reasonable and prudent parent standard" means the same as defined in Iowa Code section 237.1.

"Recruitment and retention contractor" means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents or any of its subcontractors.

"Relative" means an individual related to the child within the fourth degree of consanguinity or affinity, by marriage, or through adoption. This includes the parent of a sibling of the child if the sibling's parent's parental rights were not previously terminated in relation to the child.

"Service area manager" means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

441—125.2(237) Application for approval.

125.2(1) *Right to apply.* A relative or fictive kin of a child who has been court-ordered to placement in the relative or fictive kin's care can apply for kinship foster care approval. All applicants must be at least 18 years of age.

125.2(2) *Referrals.* A relative or fictive kin caregiver wishing to apply for kinship foster care approval shall be referred by the department or the department's contractor for kinship navigator services. The department's recruitment and retention contractor in the applicable service area shall provide the application packet and assist in completing the approval process with the applicant.

125.2(3) *Decision to operate a kinship foster home.* When an applicant decides to operate a kinship foster family home, the applicant shall complete the Kinship Foster Care Approval Application.

125.2(4) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

125.2(5) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded child abuse report of a kinship foster parent applicant will be evaluated by the department to determine if the founded abuse merits prohibition of approval.

b. The department will evaluate founded child abuse reports on a case-by-case basis. Considerations the department will take include but are not limited to whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

125.2(6) *Reports and information.* The applicant shall furnish all requested reports and information relevant to the approval determination to the department.

125.2(7) *Applications for reapproval.* The department or its agent will send an application for reapproval 90 days before the approval expires. Applications for reapproval shall be made on the form specified in subrule 125.2(3).

a. Applications for reapproval shall be made no less than 30 days but no more than 90 days before the approval expires.

b. Applications for reapproval of a kinship foster family approval shall be submitted to the recruitment and retention contractor.

c. The department will approve or deny an application for reapproval as described in rules 441—125.3(237) and 441—125.4(237).

125.2(8) *Notification.* The department will notify an applicant of the approval or denial of an initial application within 60 days of the date that the applicant is referred to the recruitment and retention contractor. The department will notify an applicant regarding reapproval within 30 days of the expiration of the initial approval.

125.2(9) *Approval.* Approved kinship foster caregiver applicants will be approved for a term of two years.

a. Thereafter, the caregiver shall apply for reapproval every two years based on the requirements of subrule 125.2(7).

b. A new notice of approval is required any time the caregiver moves to a new home.

441—125.3(237) Denial.

125.3(1) The department will deny the Kinship Foster Care Approval Application when:

a. The applicant, or any person residing in the home other than a foster child, has been convicted of a crime unless the department has evaluated the crime and concluded that the crime does not merit prohibition of approval.

b. The applicant, or any person residing in the home other than a foster child, has a record of founded child abuse unless the department has evaluated the founded abuse and concluded that the abuse does not merit prohibition of approval.

c. For just cause, due to a condition or combination of conditions that cannot be improved and prevent the kinship caregiver from caring for the child's physical, emotional, medical, or educational needs.

125.3(2) Reapplications shall be denied based on the same criteria as initial applications.

441—125.4(237) Approval procedure.

125.4(1) *Application.* Applicants for an initial approval to become a kinship foster home shall submit the Kinship Foster Care Approval Application forms directed in rule 441—125.2(237).

125.4(2) *Record checks.* Prior to approval of an application for kinship foster care, applicants shall pass the record check procedures identified in rule 441—125.7(237).

125.4(3) *Home study.* The recruitment and retention contractor shall complete a kinship foster care home study.

a. Process. Information for the home study is gathered primarily through a face-to-face interview with the identified kinship caregiver(s) in the home. Tribal agencies may also be involved in conducting home studies for American Indian and Alaska Native children. 42 U.S.C. §671(a)(26)(B) as amended to August 1, 2025, provides that any receiving state must treat any tribal home study report as meeting the requirements imposed by the state for the completion of a home study.

(1) The contractor shall hold at least one face-to-face interview with the applicant(s) with one of the interviews taking place in the applicant's home.

(2) A physical assessment of the home is required. The contractor shall use a Kinship Foster Care Home Study form to assess the physical structure of the home to verify it is safe for the child.

b. Caregiver assessment. The kinship caregiver shall be assessed to evaluate the caregiver's ability to meet the needs of the court-ordered placed child. The assessment will include the following criteria:

(1) The applicant's ability to provide for the child's physical, medical, and emotional needs; to respect the child's ethnic and religious identity; and to support the child's overall well-being.

(2) The safety of the child in relation to any animals that live on the applicant's property.

(3) Knowledge of the child's situation, the caregiver's relationship with the child, the child's family and knowledge of the child's situation and department involvement.

(4) Agreement to abstain from using physical forms of discipline.

(5) Understanding of the reasonable and prudent parenting standard and how to successfully apply the standard.

(6) The caregiver's willingness to access resources and additional supports needed for placement stability to meet the needs of their family and the child placed in their care.

(7) The caregiver's and other household members' current health status, including current prescription medications.

(8) The caregiver's previous or current challenges with mental health, substance use or both and the potential impact it may have on the caregiver's ability to care for the child.

(9) Assessment of whether previous violence was experienced in the caregiver's home and how it has been addressed.

(10) The caregiver's willingness and ability to ensure the child's attendance at school; appointments for medical, dental, and vision; activities; and to ensure family interactions with parents and siblings.

(11) Assessment of the caregiver's ability and willingness to commit to the child, to work with the department, and to be considered as a long-term permanency option.

(12) Understanding of household composition, who has access to the child, other adults and children in the household, relationship status of household members and family dynamics.

(13) Description of the caregiver's available formal and informal supports to ensure child safety and well-being.

c. *Physical home assessment.* The physical home assessment shall assess the following areas of the applicant's home and address necessary steps to mitigate concerns when identified:

(1) General description of the dwelling including the number of bedrooms, bathrooms, and shared areas of the home.

(2) Determination of any signs of home infestation by rodents, insects, or other pests.

(3) Existence of external hazards such as nearby traffic, accessibility of pools/hot tubs, nearby bodies of water, railroad tracks, waste materials, or contaminated water.

(4) Existence of internal hazards that pose a risk of harm created by the physical structure of the home such as broken or missing stairs, exposed wires, large holes in the floor, broken windows, or other physical hazards.

(5) Accessibility of hazardous materials or items in the home or on the property and the means to make them inaccessible to the child in an age-appropriate way or used with appropriate supervision.

(6) Evaluation of a child's access to the following:

1. Firearms and projectile weapons.
2. Medications.
3. Strong or toxic chemicals such as detergents, bleach, and gasoline.
4. Tools, machinery, farm equipment, lawn mowers, and trampolines.
5. Potable water.

(7) Evaluation of the sleeping arrangements for children placed in the home including:

1. Planned sharing of sleeping spaces.
2. Where children will have privacy to change clothes.
3. If supports are needed to provide beds, bedding, or establish opportunities for privacy.
4. Discussion of safe sleeping practices for children aged one and younger.

(8) Ability to ensure the child's access to age-appropriate personal hygiene (bathing, brushing teeth, wearing clean clothing).

(9) Ability to protect the child in an age-appropriate manner from pets or animals.

(10) Age-appropriate safe seat restraints (car seat, seatbelt, etc.) in personal vehicles used to transport the child.

(11) Ability to provide the child ongoing access to adequate, nutritious, age-appropriate food, including the ability to keep perishable items cold.

(12) Understanding of the child's dietary needs related to cultural/religious traditions, medical needs, and allergies.

(13) A plan for fire safety, including an escape plan and smoke detectors.

(14) Ability to create a safety plan that includes the ability to contact emergency services for assistance within a reasonable distance (neighbor's home, local business, etc.)

(15) Description of support mechanisms needed for the caregiver to address any barriers to meeting the physical needs of the home to ensure the safety and well-being of the child and steps taken to address the needs during the approval process.

d. Written report. The recruitment and retention contractor shall prepare a written report of the caregiver assessment. This assessment shall include a recommendation for approval or denial of the application and any other pertinent information in making the recommendation. The home study shall be maintained in the kinship caregiver's record maintained by the department.

125.4(4) *Decision and notice of action.* The department will use the home study and the recommendation of the recruitment and retention contractor to approve or deny a caregiver for kinship foster care.

a. The department will notify the family of the decision in writing.

b. If the department does not approve the home study, a notice will be issued according to the provisions of 441—Chapter 16 and state the reasons for that decision as listed in rule 441—125.3(237).

c. A denial may be appealed pursuant to the provisions set forth in 441—Chapter 7.

441—125.5(237) Involvement of kin.

125.5(1) *Support by kinship foster caregiver.* Kinship foster caregivers shall support the involvement of biological or adoptive parents and other relatives of the child unless this involvement is evaluated and documented by the department to be detrimental to the child's well-being.

125.5(2) *Nature of involvement.* The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the kinship foster caregivers, biological or adoptive parents, and other members involved with the child and family.

125.5(3) *Cultural connections.* Throughout the provision of care, the kinship foster caregiver shall actively ensure that the child stays connected to the child's kin, culture, and community as required in the child's case permanency plan.

441—125.6(237) Information on the child placed in the home.

125.6(1) *Information about the child.* Kinship foster caregivers shall maintain a separate file of information on the child placed in the home to include contact information for all medical, dental, vision, hearing and mental health professionals for the child; current medications for the child; school reports and school pictures received; and the date, name, address and phone number of the person to whom the child was discharged at the end of placement. This file shall be provided to the department or the child's parent or guardian when the child leaves the placement.

125.6(2) *Confidentiality.* Kinship foster caregivers shall maintain confidentiality regarding the child in their placement, except as required to comply with rules on mandatory reporting of child abuse and with the child's case permanency plan. Kinship foster caregivers shall not without parent, guardian and department consent post pictures or information concerning the child on any internet website or on social media.

441—125.7(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 18 years of age or older living in the home of the applicant. The purpose of the record checks is to determine whether any of these persons has any founded child abuse or dependent adult abuse reports or criminal convictions or has been placed on the sex offender registry.

125.7(1) *Procedure.* The department's contractor for recruitment and retention shall assist applicants in completing required record checks, including fingerprinting.

125.7(2) *Iowa records.* Each applicant and anyone who is 18 years of age or older living in the home of the applicant shall be checked for records with:

a. The Iowa central abuse registry;

b. The Iowa division of criminal investigation;

c. The Iowa sex offender registry; and

d. Iowa Courts Online.

125.7(3) *Other records.* Each applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years.

a. Each applicant shall also be fingerprinted for a national criminal history check.

b. Fingerprinting, for the purpose of a national criminal history check, is required on all identified applicants who will have a caretaker role with the child placed in the home at the time of initial application.

c. When warranted, the department may require fingerprinting for a national criminal history check on other adult household members at initial application or who move in after initial application.

125.7(4) *Evaluation of record.* If the applicant or anyone living in the home has a record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department will not approve the applicant for kinship foster care unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

125.7(5) *Exclusion.* An evaluation will not be performed if the person has been convicted of:

a. A felony offense as set forth in Iowa Code section 237.8(2)*"a"*(3); or

b. A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2)*"a"*(3).

125.7(6) *Scope.* The evaluation will consider the nature and seriousness of the founded child or dependent adult abuse or crime in relation to:

a. The position sought or held;

b. The time elapsed since the abuse or crime was committed;

c. The circumstances under which the crime or founded abuse was committed;

d. The degree of rehabilitation;

e. The likelihood that the person will commit the abuse or crime again; and

f. The number of abuses or crimes committed by the person.

125.7(7) *Evaluation form.* The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return to the department the Record Check Evaluation Form, within ten calendar days of the date of receipt, to be used to assist in the evaluation. Failure of the person to complete and return the Record Check Evaluation Form to the department within the specified time frame shall result in denial of approval.

125.7(8) *Evaluation decision.* Centralized service area staff or designees will conduct the evaluation and make the decision. The department will inform the subject of the decision and describe the basis of the decision using the criteria specified in subrule 125.7(6). The department will send the form to the person on whom the evaluation was completed:

a. Within 30 days of receipt of the completed form, or

b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified.

125.7(9) *Reapproval.* Applicants approved for kinship foster care who apply for reapproval shall be subject to the same checks as new applicants, except for fingerprinting. The department will evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation will be conducted using the same process as described in rule 441—125.7(237).

441—125.8(237) Medical examinations and health care of the child.

125.8(1) *Medical and dental care.* Kinship foster caregivers shall keep the child's department case manager informed of any medical and dental appointments as well as any treatments prescribed for the child.

a. The department may delegate its authority, as custodian, to consent to routine and emergency medical care to a licensed foster parent or approved kinship foster caregiver.

b. Routine medical care includes but is not limited to the following areas:

(1) Preventive care, also known as wellness care, not including the administration of a vaccination. Parents or guardians of the child must provide consent for administration of a vaccination.

(2) Non-emergency medical care including but not limited to a physical examination, a diagnostic laboratory test, or a medical visit for a minor illness.

(3) Routine dental and vision care, including cleanings and annual examinations.

(4) Use of necessary medication, including but not limited to antibiotics. This does not include psychotropic/mental health medications. Parents or guardians of the child must provide consent for the administration of new psychotropic/mental health medications.

c. When routine and emergency medical consent has not been delegated by the department to the approved kinship foster caregiver:

(1) Kinship foster caregivers shall contact the child's parents to engage them in the process of accessing routine medical and dental care for their child unless parental rights have been terminated.

(2) In case of an emergency or urgent situation requiring medical care and treatment of an acute illness, disease or condition of the child, when a delay or inability to access parental or department consent for medical care or treatment would endanger the health or physical well-being of the child, kinship foster caregivers can provide consent for medical care and treatment.

125.8(2) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization that is against medical treatment for disease.

a. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record.

b. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

441—125.9(237) Training and discipline of child.

125.9(1) *Methods of training and discipline.* The home study evaluation of each applicant shall include a discussion and a written assessment of the kinship foster caregivers' methods of training and discipline. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

125.9(2) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the department and the caseworker for the child will be investigated by the department promptly and referred to the proper authorities when necessary.

441—125.10(237) Emergency care and release of child.

125.10(1) *Supervision and arrangements for emergency care.* Kinship foster caregivers shall provide supervision of the child in preadoptive placement as dictated by the individual child's specific needs.

a. In case of emergency requiring the kinship foster caregiver's temporary absence from the home, arrangements shall be made with designated, responsible persons for the care of the child during the period of absence.

b. The department shall be notified of all emergency absences of the kinship foster caregivers.

125.10(2) *Release of child.* The kinship foster caregivers shall release the child only to the agency, a parent or guardian from whom the child was received for care, or the person specifically designated by the agency, parent or guardian.

441—125.11(237) Changes in kinship foster care home. Kinship foster caregivers shall notify the department and the recruitment and retention contractor within 30 working days of:

1. Any change in the persons living in the home (except for the child placed in the home);
2. A move to a new home; or
3. Any circumstances in the home that could negatively affect the health, safety or welfare of the child in the family's care.

These rules are intended to implement Iowa Code chapter 237 and section 234.40.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 151
"Juvenile Court-Ordered Services"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 232.191
State or federal law(s) implemented by the rulemaking: Iowa Code section 232.191

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter underwent a fulsome review as a part of the Red Tape Review process laid out in Executive Order 10. As a result of this review, restrictive terms were removed, areas that were duplicative were combined or eliminated, and editorial updates were made to processes and procedures to ensure they reflect current policies and procedures. These proposed rules prescribe services for eligible children for reimbursement from funds appropriated specifically for juvenile court services directed programs. The proposed rules establish the criteria for the allocation of funds and the procedures for administration, application, eligibility, appeals, service delivery, and billing and payment. These proposed rules also prescribe the joint responsibilities of the chief juvenile court officers and the Department's service area managers for the planning and implementation of an annual child welfare and juvenile justice plan for each Department service area.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

This proposed rulemaking does not bear a cost to the public.

- **Classes of persons that will benefit from the proposed rulemaking:**

This proposed rulemaking is meant to benefit the welfare of juveniles who have court-ordered services.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

This rulemaking will help clarify what court-ordered services are covered by the State and what services are not.

- **Qualitative description of impact:**

Those involved in the juvenile court system will benefit from clarified rules regarding expenses covered by court-ordered services.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs associated with enforcement of this proposed chapter.

- **Anticipated effect on State revenues:**

This rulemaking is not expected to have any impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

The funding of juvenile court-ordered services is required by Iowa Code chapter 232.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This rulemaking is not expected to have any impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 151 and adopt the following **new** chapter in lieu thereof:

CHAPTER 151
JUVENILE COURT-ORDERED SERVICES

441—151.1(232) Definitions.

"Child" means a person under 18 years of age.

"Child welfare services" means services to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Court-ordered services" means the defined or specific care and treatment that are authorized by the court for an eligible child or the parent of an eligible child and for which no other payment source is available to cover the cost.

"Eligible child" means a child supervised by the department for whom the juvenile court judge has provided an order for a service funded under court-ordered services.

"Provider" means a public agency, including a school district or government unit, or a private agency, organization or eligible individual authorized to do business in the state. The provider is also known as the claimant.

"Service area" means one of the five geographic areas designated by the department for the provision of family well-being and protection services.

441—151.2(232) Administration of funds for court-ordered services. Pursuant to the authority granted in Iowa Code chapters 7E, 8, 232, and 602 and the annual appropriations Acts, the executive branch, represented by the department, and the judicial branch, represented by the juvenile court judges, are each charged with specific responsibilities for funding, administering, and providing court-ordered services.

151.2(1) *Allocations for court-ordered services.* Court-ordered services are funded by an appropriation made to the department.

151.2(2) *Court order requirement.* Upon the request of any party, the court may authorize the use of court-ordered services for child welfare services as defined in subrules 151.4(1) and 151.4(2).

151.2(3) *Application for funds.* The department will complete an application for the use of court-ordered service funds upon receiving the order.

151.2(4) *Availability of funds.* The department will have the opportunity to establish the availability of funds once an authorization for court-ordered services is received from the court.

151.2(5) *Monitoring of funds.* The department will monitor and communicate the availability of the court-ordered services funds to ensure that funds are available throughout the state fiscal year.

151.2(6) *Emergency or after-hours situations.* Any services that are provided without the signed approval of the department's approved administrator may be denied payment, unless there is an emergency or after-hours situation and no other provision exists for handling emergency or after-hours situations or transports.

151.2(7) *Transfer of funds to a decategorization governance board for administration.* Funds allocated to the department for court-ordered services may be transferred to a decategorization governance board for administration.

151.2(8) *Billing and payment.* The department will ensure that billing and payment are in compliance with the requirements of the accounting policies and procedures manual of the department of administrative services, state accounting enterprise as amended to August 1, 2025. A claim that meets the requirements of this chapter becomes a state liability on the date of a claim's accrual. The date of a claim's accrual is the date the service was provided, the end of the agreed-upon billing interval specified in the contract, or the date of a determination of liability for the claim.

441—151.3(232) Use of other funding sources. The department, in cooperation with juvenile court judges, will ensure that the funds allocated for court-ordered services are spent only after all other reasonable actions have been taken to use other funding sources. Services are not eligible for reimbursement when another payment source is available.

151.3(1) The department will maximize the use of funds that may be available from the Medicaid program, including coverage for early and periodic screening, diagnosis, and treatment and for psychiatric medical institutions for children (PMIC), before requesting assistance through the court-ordered services fund. However, medical cost sharing for the one-time payment per court

order of a deductible amount or a coinsurance amount for treatment specified in a court order is an allowable expense that may be paid through the court-ordered services fund when insurance or Medicaid is then available to pay the remainder of the cost.

151.3(2) The department may recover payments from any third-party insurance carrier that is liable for coverage of the services, including health insurance coverage. The department may submit claims to third-party insurance carriers liable for coverage of the services before the claims are submitted for payment through the court-ordered services fund.

151.3(3) The date of a medical claim's accrual for reimbursement through court-ordered services is the date the claim becomes a state liability. For example, a claim becomes a state liability on:

a. The date of a court order for a contested claim; or

b. The date of a determination by Medicaid or private insurance that Medicaid or private insurance denies partial or full payment for care and treatment for which an application has been made.

151.3(4) If eligible for reimbursement through the court-ordered services fund, medical claims that are submitted to, but are denied by, Medicaid or private insurance will be paid at a rate not to exceed the rate set by Medicaid.

151.3(5) Allowable rates not available. When the department has been unable to establish an allowable rate of reimbursement for a service or a provider, the department's approved administrator or designee will negotiate a reimbursement rate with the provider to obtain the service at a reasonable cost based on available community or statewide rates.

441—151.4(232) Expenses. The following lists of expenses that are eligible for reimbursement from the court-ordered services fund are intended to be exhaustive. Billings for services not listed in subrule 151.4(1) cannot be paid except as provided in subrule 151.4(2).

151.4(1) *Expenses to be reimbursed.* The expenses for which reimbursement will be made include:

a. Expenses, other than salary, incurred by a person ordered by the court, other than a juvenile court officer, in transporting a child to or from a place designated by the court, including mileage, lodging and meals.

b. The expense of care or treatment ordered by the court whenever the minor is placed by the court with someone other than the parents; or a minor is given a physical or mental examination or treatment under order of the court; or, upon certification by the department, a minor is given physical or mental examinations or treatment with the consent of the parent, guardian or legal custodian relating to a child abuse investigation and no provision is otherwise made by the law for payment for the care, examination, or treatment of the minor. Care and treatment expenses for which no other provision for payment is made by law that will be reimbursable include court-ordered:

(1) Individual services for the child separate from a family's treatment plan.

(2) Diagnosis and evaluation on an outpatient basis unless the diagnosis and evaluation is provided by a person or agency with a contract with the department for the service for which the child is eligible.

(3) An evaluation of a child in a residential facility.

(4) Inpatient (hospital) evaluation of a child previous to disposition.

(5) Medical treatment for a child. This includes medical treatment while in detention in a facility used for detention when the medical treatment is court-ordered.

(6) Drug treatment, testing and care for a child.

(7) Intensive in-home supervision and monitoring and alternatives to shelter care unless a person or agency that has a contract with the department provides the service for which the child is eligible.

(8) Evaluation of parents pursuant to an adjudication unless the diagnosis and evaluation is provided by a person or agency with a contract with the department for that service for which the child is eligible.

(9) Physical or mental examinations ordered pursuant to Iowa Code section 232.49 or 232.98 or those eligible for payment pursuant to Iowa Code chapter 249A.

(10) Services ordered under family in need of assistance proceedings unless a person or agency with a contract with the department provides the service for which the child is eligible.

(11) Expenses for all educational testing or programming for children, not weighted as special education students, who attend an on-campus school in an out-of-state facility.

(12) Expenses for educational testing or programs related to a high school equivalency diploma or for credit hours, when the expenses are not required to be paid by the state.

(13) Medical cost sharing for payment of a deductible amount or a coinsurance amount when Medicaid or private insurance is then available to pay the remainder of the cost.

151.4(2) *Expenses not listed.* Expenses not covered in subrule 151.4(1) will be eligible for reimbursement from court-ordered service funds only under the following circumstances:

a. The expense is for a child welfare service;

b. The expense is authorized by the court;

c. The reimbursement is not in conflict with current law or administrative rule, and

d. No alternative funding sources are available to pay for the service.

These rules are intended to implement Iowa Code section 232.141.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 306
"Opioid Settlement Fund Disbursement"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 12.51 as amended by 2025 Iowa Acts, House File 1038

State or federal law(s) implemented by the rulemaking: Iowa Code section 12.51 as amended by 2025 Iowa Acts, House File 1038

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter is intended to implement division I of 2025 Iowa Acts, House File 1038, by adopting rules to outline the Department's responsibilities in the distribution of funds from the State of Iowa's Opioid Settlement Fund.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

The entities that manufactured, marketed, sold, distributed, dispensed, or promoted opioids, and made payments to settle claims arising from the manufacturing, marketing, selling, distributing, dispensing, or promoting of opioids paid the money that is allocated to the Opioid Settlement Fund created in Iowa Code section 12.51.

- **Classes of persons that will benefit from the proposed rulemaking:**

Individuals struggling with opioid addiction will ultimately benefit from the programs supported by funds as disbursed pursuant to these proposed rules.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

During State fiscal year (SFY) 2025, over 20 opioid abatement projects were supported by funds from the State's Opioid Settlement Fund. In total, $29 million was obligated to the identified projects.

Beyond this funding, an additional $27 million of accrued settlement funds is available for opioid remediation. How this funding will be utilized remains to be determined, but it will not result in additional costs to the Department beyond what is allowed for as part of the settlement agreement.

- **Qualitative description of impact:**

Individuals struggling with opioid addiction will ultimately benefit from the programs supported by funds as disbursed pursuant to these proposed rules. The projects and programs supported through the Opioid Settlement Fund will utilize *Exhibit E. The List of Opioid Remediation Uses* as a reference point, ensuring that the full continuum of prevention, early intervention, treatment, recovery, and crisis services are available to any individual impacted by the opioid crisis.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs associated with implementing this proposed rulemaking.

- **Anticipated effect on State revenues:**

This proposed rulemaking has no impact on State revenues beyond the $29 million appropriated by the underlying legislation from the Fund to the Department for FY 2024 and FY 2025.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

The proposed rulemaking is required by division I of 2025 Iowa Acts, House File 1038.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

The proposed rulemaking is required by division I of 2025 Iowa Acts, House File 1038.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Adopt the following **new** 441—Chapter 306:

CHAPTER 306
OPIOID SETTLEMENT FUND DISBURSEMENT

441—306.1(12) Definition.

"Fund" means the opioid settlement fund created in Iowa Code section 12.51.

441—306.2(12) Methodology. To facilitate the fund disbursement required by Iowa Code section 12.51, the department may solicit requests for proposals pursuant to rules of the department of administrative services each fiscal year, starting with the fiscal year beginning July 1, 2025. The department may pursue additional funding mechanisms as fund availability and opportunities allow.

441—306.3(12) Outcome measurement. Subsequent to the awarding of disbursements, the department will formulate indicators to be used to help identify if the outcomes intended for each disbursement are being met. Intended outcomes can include but are not to be limited to prevention of opioid-related deaths, reduction of opioid misuse, and increased access to appropriate medication and services.

441—306.4(12) Annual report. Starting with the fiscal year beginning on July 1, 2025, on or before November 1, the department will annually submit to the general assembly and to the governor a report that includes the elements required by Iowa Code section 12.51*"b"*(3)(d).

These rules are intended to implement Iowa Code section 12.51 as amended by 2025 Iowa Acts, House File 1038.

Regulatory Analysis

Notice of Intended Action to be published: 265—Chapter 9
"Title Guaranty Division"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 16.5 and 16.91

State or federal law(s) implemented by the rulemaking: Iowa Code sections 16.2A, 16.4C, 16.5, 16.90 through 16.93, 17A.10, and 535.8

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9:30 to 9:45 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-finance-authority/ifa-red-tape-review

Public Comment

Any interested person may submit written comments concerning this Regulatory Analysis, which must be received by the Iowa Finance Authority (Authority) no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Lisa Connell
Iowa Finance Authority
1963 Bell Avenue, Suite 200
Des Moines, Iowa 50315
Email: lisa.connell@iowaeda.com

Purpose and Summary

The Authority proposes to rescind Chapter 9 and adopt a new chapter in lieu thereof. The chapter describes the structure, policies, and procedures of the Iowa Title Guaranty division (division) of the Authority. The updated chapter reflects changes to the division structure in 2025 Iowa Acts, Senate File 975.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

Participants in the title guaranty program (program) pay an annual renewal fee pursuant to Iowa Code section 16.91(4). The division collects a fee to provide a mortgage release certificate. The division charges premiums for the certificates and endorsements it issues.

- **Classes of persons that will benefit from the proposed rulemaking:**

Applicants and participants will benefit from an updated chapter that reflects changes to the division structure in 2025 Iowa Acts, Senate File 975.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Participants in the program pay an annual renewal fee pursuant to Iowa Code section 16.91(4). The division collects a fee to provide a mortgage release certificate. The division charges a premium for the certificates and endorsements it issues.

- **Qualitative description of impact:**

The proposed rulemaking will provide clarity about the division's structure, policies, and procedures.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

Division staff time is required to evaluate and approve applications from participants and to administer the program. Such costs are covered by fees and premiums collected by the division.

- **Anticipated effect on State revenues:**

The rulemaking has no anticipated impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

The proposed rulemaking does not impose any additional costs compared to the existing Chapter 9.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

The Authority has not identified any less costly methods or less intrusive methods for administering the program.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

The Authority did not consider any other methods.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

The Authority did not consider any other methods.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

The proposed rulemaking does not have a substantial impact on small business. The application and monitoring requirements related to the program are no more than necessary to administer the statutory requirements and purposes of the program. The rules do not establish design or operational standards.

Text of Proposed Rulemaking

ITEM 1. Rescind 265—Chapter 9 and adopt the following **new** chapter in lieu thereof:

CHAPTER 9
TITLE GUARANTY DIVISION

265—9.1(16) Definitions. The following words and phrases, when used in this chapter, shall have the meanings set forth below unless a meaning is inconsistent with the manifest intent or the context of a particular rule:

"Abstract" means a written or electronic summary of all matters of record affecting title to a specific parcel of real estate prepared in accordance with abstract minimum standards adopted by the division provided, however, that for nonpurchase transactions, "abstract" may also mean a written or electronic short-form summary setting forth the titleholders, liens, and encumbrances in accordance with guidelines adopted by the division.

"Abstractor" means a person who is engaged in the practice of searching public records for the purpose of creating abstracts.

"Authority" means the Iowa finance authority established by Iowa Code chapter 16.

"Authority board" means the board of directors of the authority created pursuant to Iowa Code section 16.2.

"Certificate" means the form used to guarantee title, including any part or schedule thereof and any endorsements thereto.

"Claim" means loss or damage or potential loss or damage arising by reason of a matter actually, possibly, or allegedly within the coverage of a commitment, certificate, closing protection letter, mortgage release certificate, or by reason of any other matter for which the division is actually, possibly, or allegedly liable.

"Claim loss" means amounts paid by the division in the investigation and resolution of a claim, including but not limited to payments to the guaranteed, payments to adverse claimants, attorneys' fees, and all other expenses and costs related to or arising from the claim.

"Closing protection letter" means the division's written agreement to indemnify a lender or borrower or both for loss caused by a participating closer's theft of settlement funds or failure to comply with written closing instructions relating to title certificate coverage when agreed to by the participating closer.

"Commitment" means the division's written offer to issue a certificate and any endorsements thereto.

"Division" means Iowa title guaranty, a division of the authority.

"Field issuer" means a participant authorized by the division to issue commitments and certificates.

"Mortgage release certificate" means a certificate of release or a certificate of partial release issued by the division pursuant to Iowa Code section 16.92.

"Participant" means a participating attorney, a participating abstractor, or a participating closer.

"Participating abstractor" means an abstractor who is authorized by the division to prepare abstracts for division purposes.

"Participating attorney" means an attorney licensed to practice law in the state of Iowa who is authorized by the division to prepare title opinions for division purposes.

"Participating closer" means any of the following authorized by the division to issue a closing protection letter: an Iowa licensed attorney disbursing funds through an interest on a lawyer trust account, a closing agent licensed by the Iowa division of banking, or a real estate broker licensed by the Iowa real estate commission disbursing funds through a real estate trust account.

"Party" means a participant, or any other person, who has a contractual relationship with the division to provide services for which a claim may be brought against the division.

"Person" means an individual or legal entity, including a corporation, a limited liability company, a government or governmental subdivision or agency, a business trust, an estate, a trust, a partnership or association, or any other legal entity.

265—9.2(16) Mission. The mission of the division is to operate a program that offers guaranties of real property titles in order to provide, as an adjunct to the abstract-attorney's title opinion system, a low-cost mechanism to facilitate mortgage lenders' participation in the secondary market and add to the integrity of the land-title transfer system in the state of Iowa and to perform other duties as assigned by Iowa law.

265—9.3(16) Organization. The office of the division is located at the address set forth in rule 265—1.3(16). Office hours are 8 a.m. to 4:30 p.m. Monday through Friday, excluding legal holidays. The division's website address is www.iowatitleguaranty.com, and the division's telephone number is 515.452.0484. The division's email address is titleguaranty@iowafinance.com. Inquiries, submissions, applications and other requests for information may be directed to the division by the methods set forth herein.

265—9.4(16) Operation. The division offers guaranties of real property titles in the state through the issuance of commitments and certificates.

9.4(1) *Commitments, certificates, forms and manuals.* The terms, conditions, and form of commitments and certificates shall be approved by the authority board. The division may adopt and use manuals and other forms as the division deems necessary for implementation and administration of the title guaranty program.

a. The division will provide forms to a participant for use in issuing commitments and certificates on behalf of the division. A participant may not alter any form supplied by the division or use a form supplied by another person to bind the division. In addition, the participant shall not transfer or attempt to transfer unissued commitments or certificates to another participant or other person unless authorized in writing by the division.

b. In addition to the division's other rights and remedies, the division may refuse to allow the participant access to any forms until the participant complies with the requirements of this chapter to the satisfaction of the division.

c. A participant shall be liable to the division for loss or damage sustained by the division by reason of the failure of the participant to comply with the requirements of this rule.

9.4(2) *Application for commitments and certificates.* The division will make an application for commitments and certificates available on the division's website.

9.4(3) *Rates.* Rates for commitments, certificates and closing protection letters shall be set pursuant to Iowa Code section 16.91(1). In transactions involving extraordinary risk or unusual or unique endorsements, the division may assess additional charges.

265—9.5(16) Participants.

9.5(1) *General provisions.* An applicant shall submit a participant application and the first year's annual fee and shall sign a participation agreement in order to be authorized to provide one or more services on behalf of the division.

9.5(2) *Participant application.* Applications for participation and renewal are available on the division's website. An applicant shall submit an application to provide one or more services on behalf of the division. If the applicant is approved as a participant, the participant is required to submit a renewal application annually.

9.5(3) *Eligibility considerations.* To determine whether to approve or deny a participant application, factors the division may consider include but are not limited to the following:

a. The needs of the public and the needs of existing or potential customers of the applicant.

b. A history of the operation and management of the applicant's business.

c. The character, fitness, financial responsibility and experience of the applicant and the applicant's employees.

d. A credit report or criminal background check of the applicant or the applicant's employees.

e. A record of default in the payment of moneys collected for others by the applicant or the applicant's employees.

f. A history of discharge of debts by the applicant or the applicant's employees through bankruptcy proceedings.

g. Compliance with the title and settlement best practices adopted by the division.

h. Other factors as determined by the division.

9.5(4) *Participation agreement.* The participation agreement sets forth the contractual relationship between the participant and the division. A new participation agreement is executed annually and when otherwise required by the division.

9.5(5) *Annual fee.* A participant may be required to pay an annual fee of $75, set pursuant to Iowa Code section 16.91(4).

9.5(6) *Agent relationship.* A participant is only authorized to act as an agent of the division for the purposes and in the manner set forth in the participant's participation agreement, the Iowa Code, these rules, manuals and any other written instructions given by the division. The authority of a participant to act as an agent of the division is not exclusive and is subject to the rights of the authority, the division, and other participants, agents, or representatives of the division.

9.5(7) *Conflict of interest.* A participant shall not, without prior authorization of the division, prepare an abstract or issue a title opinion, commitment, certificate, or closing protection letter for a transaction in which the participant has a personal or financial interest in the real estate that is the subject of that transaction.

9.5(8) *Clearance of title objections.* All title objections must be cleared in accordance with applicable division manuals and any other written instructions given by the division prior to the issuance of a certificate. Any underwriting determination about which there may be a bona fide difference of opinion among attorneys, which is not specifically addressed by division manuals or instructions, shall be approved by the division in writing.

9.5(9) *Commitment and certificate coverage limitations.* A field issuer shall obtain written authorization from the division prior to issuing a commitment or certificate that exceeds the allowable maximum amount of coverage as determined by the division. If authorization under this subrule is not obtained through the act or omission of the field issuer, the field issuer shall be strictly liable to the division for any loss or damage resulting from issuance of the commitment, closing protection letter, or certificate.

9.5(10) *Document retention.* A participant shall maintain transaction files in such a manner that information pertaining to activities of the participant is readily available to the division while protecting confidential client information. A participant shall retain files for a period of ten years after the issued date of the certificate or the issued date of the commitment if a certificate is not issued.

9.5(11) *Training.* The division may require a participant and the participant's staff to participate in training sessions or continuing education seminars as deemed necessary by the division to ensure compliance with division requirements and procedures.

9.5(12) *Compliance.* Participants shall comply with the Iowa Code, these rules, the participation agreement, manuals, and any other written instructions given by the division. The division may audit the participant, with or without notice, for verification of compliance. An audit may include but not be limited to a review of the participant's abstracts, title opinions, commitment and certificate issuance procedures, a test of title plants and tract indices, and a review of closing policies and procedures and escrow account details.

9.5(13) *Revocation.* The division may revoke a participant's authorization to provide services on behalf of the division for reasons, including but not limited to the following:

a. Failure to comply with the terms and conditions of the participation agreement.

b. Failure to submit an annual renewal application.

c. Knowingly withholding or misrepresenting material facts relied upon by the division.

d. Fraud, theft, dishonesty, or misappropriation of funds or documents.

e. Deterioration of the participant's financial condition adversely affecting the participant's ability to provide services on behalf of the division.

f. A finding by the division director of material noncompliance with the Iowa Code, these rules, manuals, and any other written instructions given by the division.

g. Other factors as determined by the division.

265—9.6(16) Services offered.

9.6(1) *Abstracting.* Abstracts utilized for division purposes must be prepared by a participating abstractor.

a. Title plant. A participating abstractor shall own and maintain, or lease and use, a title plant, including tract indices for each county in which that participating abstractor prepares abstracts for division purposes, unless exempt under Iowa Code section 16.91(5)*"a"*(2) and paragraph 9.6(1)*"c"* or authorized under Iowa Code section 16.91(5)*"b"* and paragraph 9.6(1)*"d."* Each of the tract indices shall be designated to encompass a geographical area of not more than one block in the case of platted real estate, nor more than one section in the case of unplatted real estate. The tract indices shall include a reference to all of the instruments affecting real estate recorded in the office of the county recorder, and the tract indices shall commence not less than 40 years prior to the effective date of the abstractor's participation in the title guaranty program. A government-maintained and -controlled database is not considered a title plant for division purposes.

b. Intent to build title plant. The division may authorize an abstractor who is building or who intends to build a title plant to prepare abstracts for division purposes upon review of the following:

(1) The abstractor's business plan;

(2) Evidence that a title plant will be built for a specific county or counties within three years of authorization;

(3) A timeline for completion of the title plant; and

(4) A description of the applicant's abstracting experience.

c. Exemption. The exemption available pursuant to Iowa Code section 16.91(5)*"a"*(2) is unique to the participating attorney, is nontransferable, and terminates at such time as the participating attorney ceases providing abstracts for division purposes or upon the death or incapacity of the participating attorney.

d. Title plant waivers. The division recognizes the 40-year title plant as the preferred method of providing title evidence for the purpose of issuing commitments and certificates. The division must weigh the benefits of the traditional title plant with other alternatives to ensure buyers and lenders a high quality of certificates throughout the state, rapid service, and a competitive price.

(1) General provisions. The division shall consider an application for a title plant waiver upon submission by an attorney or an abstractor.

(2) Submission of application. The division shall accept applications in the same manner as provided in subrule 9.5(2).

(3) Content of application. The applicant must provide, at a minimum, the following information:

1. The name, business address, email address, and telephone number of the applicant;
2. The applicant's business plan;
3. The county or counties in which the applicant intends to abstract;
4. A description of the applicant's abstracting experience;
5. Samples of abstracts prepared by the applicant;
6. A history of any professional disciplinary action against the applicant;
7. Professional references in support of the applicant;
8. The relevant facts that the applicant believes would justify a waiver under Iowa Code section 16.91(5)*"b"*; and
9. A signed statement from the applicant attesting to the accuracy of the facts provided in the application.

(4) Notification and response.

1. The division shall notify the applicant upon receipt of a complete application.

2. The Iowa State Bar Association and Iowa Land Title Association shall be provided notice of an application. Provision of the notice to the identified associations is not a requirement for the division to consider the application, and failure to inform an interested person of an application shall not void or otherwise nullify any action or decision of the division.

(5) Conditions. A waiver is unique to the recipient and is nontransferable. The division may limit a waiver as to county, transaction type, duration, or any other limitation. The division may require a waiver recipient to provide a guarantee, performance bond, or other form of indemnification as assurance for abstracts prepared by the waiver recipient on behalf of the division. The division may review the waiver annually and may require a renewal, modification or addition to any required assurances. An applicant may only retain a waiver if the applicant continues to meet the requirements for a participant in rule 265—9.5(16). If the waiver recipient fails to meet the terms of the recipient's participation agreement, the waiver may be withdrawn by the division.

(6) Withdrawal of a waiver. A waiver issued by the division may be withdrawn or modified if, after public notice and authority board meeting, the authority board issues a written ruling finding any of the following:

1. That the waiver recipient knowingly withheld or misrepresented material facts relied upon by the division in granting the waiver; or

2. That the waiver recipient failed to comply with all conditions contained in the written ruling; or

3. That the abstracts prepared by the waiver recipient fail to meet the abstract minimum standards adopted by the division; or

4. That the division has revoked the waiver recipient's authorization to provide services on behalf of the division pursuant to subrule 9.5(13).

(7) The decision of the authority board shall be final agency action, and all appeals shall be filed with the Iowa District Court for Polk County.

9.6(2) *Issuing title opinions.*

a. All title opinions shall be prepared by participating attorneys and issued in compliance with division procedures as specified in manuals and any other written instructions given by the division.

b. A participating attorney who is a field issuer may issue a commitment as the preliminary title opinion and the certificate as the final title opinion.

c. A participating attorney shall be licensed to practice law in the state of Iowa and shall be in good standing with the Iowa supreme court at all times while acting as an agent of the division.

9.6(3) *Issuing commitments and certificates.* Pursuant to a participation agreement with the division, a participant may be authorized to issue a commitment or certificate on behalf of the division. A participant's right to issue commitments and certificates is a privilege for the convenience of the division and may be terminated pursuant to terms of the participation agreement.

9.6(4) *Issuing closing protection letters.*

a. Pursuant to a participation agreement with the division, a participant may be authorized to issue a closing protection letter on behalf of the division.

b. The division may require the participating closer to provide an irrevocable letter of direction to the institution at which each escrow account is established, authorizing the division to review and audit the institution's records of such account at any time that the division, in its discretion, deems necessary.

265—9.7(16) Claims.

9.7(1) *Claim procedures.* In the event of a claim, the rights of the division and a party are as follows:

a. Upon receipt of notice by a party of a claim, the party must notify the division in writing within three business days of receipt of information about a claim by the party and shall mail

notification to the division by first-class mail at the division's address as set forth in rule 265—1.3(16) or provide notification by email.

b. When a party receives a request from the division for information with respect to a claim, the party shall supply to the division any documents, correspondence, surveys, abstracts of title, title searches, title opinions, other writings, or other information known by or available to the party and relevant to the claim, even if not specifically requested by the division.

c. A party shall cooperate fully in the investigation and resolution of a claim and shall supply any additional, new information that may come to the party's attention with such promptness as the circumstances permit.

d. The division may, with or without prior notice to the party or parties involved, investigate and resolve any claim in any manner that, in the division's sole discretion, the division may deem advisable.

9.7(2) *Claim loss recovery.*

a. Any claim losses paid are recoverable from a party by the division.

b. In the absence of knowledge by the party about the title defect or other matter causing the claim loss, the division shall not seek recovery from the party when a claim loss arises from one or more of the following:

(1) Hidden defects, including but not limited to forged deeds and mortgages, false affidavits, and false statements of marital status;

(2) Errors by public officials in maintaining and indexing the public records, including but not limited to errors by county assessors, recorders, clerks, and treasurers;

(3) Errors in these rules, manuals, and any other written instructions given by the division that the party relies upon in issuing an abstract, a title opinion, a commitment, a closing protection letter or a certificate;

(4) Errors in surveys provided by registered Iowa land surveyors that the party relies upon in issuing a certificate that provides survey coverage; or

(5) Underwriting determinations or title risks approved by the division prior to issuance of the abstract, title opinion, commitment, closing protection letter, or certificate.

c. The party shall reimburse the division for a claim loss when the division determines, in accordance with paragraph 9.7(2)*"d,"* that the party is liable and when the claim loss arises from one or more of the following:

(1) Errors by the party in the preparation of an abstract or any other report of information in the public record;

(2) Reliance by the party upon sources of title searches and other title information that had not been approved by the division at the time of the reliance;

(3) Errors made by the party in examining the title information provided in an abstract, a survey, an affidavit, or another source of title information;

(4) Errors made by the party in the preparation or review of an abstract, a title opinion, a commitment, a closing protection letter, or a certificate;

(5) Issuance of an abstract, a title opinion, a commitment, a closing protection letter or a certificate by the party with knowledge that title is defective; or

(6) Failure of the party to follow the Iowa Code, these rules, manuals, or any other written instructions given by the division.

d. Unless another rule, the Iowa Code, manuals, or any other written instruction given by the division provides for a different standard of liability or other rule for determining whether the party shall be liable for a claim loss, the division shall apply the following standards:

(1) In the event that a claim loss occurs for which the division may seek recovery from the party under subparagraph 9.7(2)*"c"*(1), the division may demand reimbursement from the party if the party was grossly negligent in preparing the abstract. Gross negligence includes the failure to make a search or the use of inadequate search procedures. Gross negligence under the preceding sentence includes but is not limited to failure to search certain indices, failure to search all names of parties

with an interest in the real estate, or failure to search in all public offices required by the division search procedures or procedures used by prudent title searchers if the division has not established specific search procedures. In making its determination whether to seek recovery, the division may consider the complexity of the public record, the reliance of the party upon division-approved search procedures, the training and experience of the person who made the error, and the existence or nonexistence of previous search errors by the party.

(2) In the event that a claim loss occurs for which the division may seek recovery from a party under subparagraph 9.7(2)*"c"*(2), the division may demand reimbursement from that party if the party relied upon sources of abstracts or other title information that had not been approved by the division at the time of the reliance.

(3) In the event that a claim loss occurs for which the division may seek recovery from the party under subparagraph 9.7(2)*"c"*(3), the division may demand reimbursement from the party if the party negligently examined the title information used in making a title determination, failed to raise an appropriate exception, waived an exception, or endorsed a commitment or certificate.

1. The division may make full review of local county abstracting standards and title standards as a guide to determine whether the party has failed to meet the standard of skill and competence of an abstractor who prepares an abstract or an attorney who examines titles in the community where the claim arose.

2. The division may also consider whether the party followed the Iowa Code, these rules, manuals, or any other written instructions given by the division in examining the title.

3. In addition, the division may seek input from other parties in the community in which the claim arose as to the standard of care of an abstractor who prepares an abstract or of an attorney who examines titles in that community.

(4) In the event that a claim loss occurs for which the division may seek recovery from the party under subparagraph 9.7(2)*"c"*(4), the division may demand reimbursement from the party if the party negligently prepared or reviewed an abstract, a title opinion, a commitment, a closing protection letter, or a certificate.

(5) In the event that a claim loss occurs for which the division may seek recovery from the party under subparagraph 9.7(2)*"c"*(5), the division may demand reimbursement from the party if the issuance of the abstract, title opinion, commitment, closing protection letter, or certificate constituted fraud, concealment or dishonesty, or if the issuance of the abstract, title opinion, commitment, closing protection letter or certificate was based upon an underwriting decision on an unusual risk that was made without contacting the division for approval.

(6) In the event that a claim loss occurs for which the division may seek recovery from the party under subparagraph 9.7(2)*"c"*(6), the division may demand reimbursement from the party if the party failed to follow the Iowa Code, these rules, manuals, or any other written instructions given by the division with respect to the matter causing the claim loss.

(7) In the event the division seeks reimbursement from a party, the division shall state the basis of the reimbursement.

265—9.8(16) Mortgage release certificate. Pursuant to Iowa Code section 16.92, the division is charged with the administration of a program to release, after proper notification, paid-off mortgages from real estate titles in Iowa by executing and filing with the county recorder a mortgage release certificate.

9.8(1) *Application.* The division will provide a mortgage release application on the division's website.

9.8(2) *Application fee.* An applicant may be required to pay a fee of $200 to apply for a mortgage release certificate. The fee shall be set by the division.

9.8(3) *Maximum principal amount of mortgage.* The authority board may set a maximum principal amount for mortgages that may be released by a mortgage release certificate.

9.8(4) *Authority to sign certificate.* A mortgage release certificate shall be executed by the division director or designee of the division director.

265—9.9(16) Rules of construction. In this chapter, the following rules of construction shall be observed:

1. The word "shall" means mandatory and not permissive and the word "may" means permissive and not mandatory.

2. Nothing contained in this chapter shall be construed to require a participating attorney to disclose privileged information of a client to the division or to any other person.

3. Any rule that provides a specific remedy or sanction for violation of the rule shall not be construed as limiting the ability of the division to pursue and enforce other remedies or sanctions under this chapter, or otherwise against a participant or other person responsible or liable, either separately, concurrently, cumulatively, or in any combination, at the sole discretion of the division.

4. The failure of the division to enforce a right or remedy under this chapter, a statute, or common law shall not be construed as a waiver of such right or remedy either in the specific instance or in any other instance.

These rules are intended to implement Iowa Code sections 16.2A, 16.4C, 16.5, 16.90 through 16.93, 17A.10 and 535.8.

Regulatory Analysis

Notice of Intended Action to be published: 661—Chapter 156
"DNA Database"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 81.4
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 81

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10:30 to 11 a.m.	125 Public Conference Room Oran Pape State Office Building Des Moines, Iowa

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Public Safety no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Josie Wagler
215 East 7th Street
Des Moines, Iowa 50319
Phone: 515.725.6185
Email: wagler@dps.state.ia.us

Purpose and Summary

Pursuant to Executive Order 10, the Department proposes rescinding Chapter 156 and adopting a new chapter in lieu thereof. The purpose of proposed Chapter 156 is to govern the administration of the DNA database and the collection, submission, analysis, identification, storage, and disposition of DNA records gathered for the database.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

Law enforcement agencies that wish to submit DNA samples to the laboratory for testing and analysis will bear the costs.

- **Classes of persons that will benefit from the proposed rulemaking:**

Law enforcement agencies from around the State will benefit from having trained laboratory staff performing forensic scientific analysis on DNA samples they submit, further aiding in investigation and prosecution of crimes.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Law enforcement agencies that wish to submit DNA samples to the laboratory for testing and analysis are responsible for transporting or mailing the evidence to the laboratory.

- **Qualitative description of impact:**

Law enforcement agencies that wish to submit samples to the laboratory for testing and analysis would be responsible for dedicating time out of the workday to personally deliver samples if they are not mailed.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

There are none.

- **Anticipated effect on State revenues:**

There is no anticipated effect on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

There is no cost for law enforcement agencies to submit DNA samples to the lab for analysis and inclusion in the DNA database. Inaction could lead to a lack of clarity surrounding the laboratory's capabilities, submission and analysis procedures, and disposition of DNA samples.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

The Department has determined this to be the least costly and least intrusive method for achieving the purpose of the proposed rulemaking.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

There were none.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This rulemaking is not anticipated to have a substantial impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 661—Chapter 156 and adopt the following **new** chapter in lieu thereof:

CHAPTER 156
DNA DATABASE

661—156.1(81) Establishment of DNA database. There is established a DNA database within the division criminalistics laboratory. These rules govern the administration of the DNA database and the collection, submission, analysis, identification, storage, and disposition of DNA records gathered for

the DNA database. These rules do not apply to the collection and handling of DNA samples gathered as evidence in the course of criminal investigations.

661—156.2(81) Definitions. The following definitions apply to rules 661—156.1(81) through 661—156.8(81):

"Administrator" means the administrator of the division criminalistics laboratory.

"Commissioner" means the commissioner of public safety.

"Database" means the DNA database located in the division criminalistics laboratory.

"Department" means the Iowa department of public safety.

"Director" means the director of the division.

"Division" means the division of criminal investigation.

"DNA" means deoxyribonucleic acid.

"Expungement" means the removal of information from the database, effectively severing any ability to link a DNA profile and an individual.

"Laboratory" means the division criminalistics laboratory.

661—156.3(81) Administration of DNA database. The database is under the direct supervision of a supervising criminalist employed by the laboratory and designated by the administrator.

661—156.4(81) Collection of DNA samples. Samples of DNA will be collected from any person required to submit a sample pursuant to the provisions of Iowa Code chapter 81.

156.4(1) The sample will be collected by the agency to which custody or responsibility for supervision has been assigned by the court issuing the sentencing order.

156.4(2) Each DNA sample will be collected as soon as is practical after an agency assumes custody or supervision of the person required to submit the DNA sample and the DNA sample is submitted to the laboratory in accordance with rule 661—156.5(81).

156.4(3) Each DNA sample will be collected using a DNA collection kit provided by the laboratory, following the instructions provided for the kit by the laboratory.

EXCEPTION: A DNA sample may be collected without the use of a DNA collection kit provided by the laboratory. If a sample is collected without the use of a kit, the person submitting the sample will include a signed and dated statement describing the collection procedure.

661—156.5(81) Submission of DNA samples.

156.5(1) All samples collected for inclusion in the database should be submitted to the following address:

Iowa DCI Criminalistics Laboratory
2240 South Ankeny Boulevard
Ankeny, Iowa 50023-9093

EXCEPTION: Each sample submitted in a package with a preprinted mailing address or with a mailing label with a preprinted address, when such package or label has been provided by the laboratory, will be mailed to the preprinted address. Any other sample will be mailed in accordance with instructions provided by the laboratory.

156.5(2) Each sample submitted will be accompanied by a completed DNA sample donor identification form included in the DNA collection kit provided by the laboratory. If the sample is submitted without the donor identification form, the sample will be accompanied by a statement signed and dated by the person submitting it, with at least the following information identifying the subject of the DNA sample: full name, date of birth, and a clear fingerprint. Additional identifying information, such as the social security number of the person providing the sample or identifying numbers assigned by state agencies, will be provided if available.

661—156.6(81) Analysis of DNA samples. Samples of DNA submitted to the laboratory will be analyzed by laboratory personnel and the results of the analysis entered into the database

in accordance with the provisions of the "Quality Assurance Standards for Convicted Offender DNA Databasing Laboratories" published by the DNA Advisory Board to the Federal Bureau of Investigation, July 1, 2025.

EXCEPTION: Analysis of DNA samples may be conducted by other laboratories under contract with the department with the approval of the administrator. Any other laboratory conducting analysis of DNA samples for inclusion in the database will comply with the requirements and procedures to which the laboratory is subject under this rule.

661—156.7(81) Identification of DNA samples. Each sample of DNA submitted for inclusion in the database will be identified by a unique number that will reference the full name of the person whose sample is submitted, the person's date of birth, and a clear fingerprint taken from the person.

661—156.8(81) Storage of DNA samples. Samples of DNA submitted for inclusion in the database will be stored at room temperature.

These rules are intended to implement Iowa Code chapter 81.

Regulatory Analysis

Notice of Intended Action to be published: 721—Chapter 22
"Voting Systems and Electronic Poll Books"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 49.29 as amended by 2025 Iowa Acts, House File 954

State or federal law(s) implemented by the rulemaking: Iowa Code section 49.29 as amended by 2025 Iowa Acts, House File 954

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 11 a.m. to 12 noon	Via videoconference call: meet.google.com/ryj-soxo-nmz

Public Comment

Any interested person may submit written comments concerning this Regulatory Analysis, which must be received by the Secretary of State no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Emma Overschmidt
First Floor
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319
Email: emma.overschmidt@sos.iowa.gov

Purpose and Summary

This proposed rulemaking would provide a temporary certification application for vendors offering electronic poll books until a complete certification process is adopted.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs of the proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

The proposed rulemaking does not create or alter benefits.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

There is no economic impact of the proposed rulemaking.

- **Qualitative description of impact:**

There is no qualitative impact of the proposed rulemaking.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

There are no costs to the Secretary of State or any other agency.

- **Anticipated effect on State revenues:**

There is no effect on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

There is no cost difference between adoption of the proposed rulemaking and inaction.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

No less costly methods or less intrusive methods exist.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

No alternative methods were considered.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

No alternative methods were considered.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

The proposed rulemaking does not have a substantial impact on small business.

Text of Proposed Rulemaking

ITEM 1. Amend rule 721—22.600(47) as follows:

721—22.600(47) Revolving loan fund. The purpose of this rule is to establish an e-poll book and polling place modernization panel to review applications submitted to the state commissioner for distribution of moneys from the revolving loan fund ~~created by 2017 Iowa Acts, House File 516, section 37, to be codified at~~ created in Iowa Code section 47.11.

22.600(1) Definitions.

"E-poll book" is as defined in rule 721—22.1(52).

"Vendor," for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.600(2) In order to ensure that the public funds in this rule are used responsibly and efficiently, this rule creates a panel consisting of designees of the state commissioner of elections, the state auditor, and the director of the department of management. Attendance by two of the three members constitutes a quorum. The panel shall conform to the party ~~and gender~~ balance requirements of Iowa Code ~~sections 69.16 and 69.16A~~ section 4A.12.

22.600(3) The state commissioner shall convene the panel whenever necessary to review loan applications received from county commissioners requesting moneys from the fund.

22.600(4) The state commissioner may convene the panel to review proposed expenditures for updating technology standards for elections. If the state commissioner determines that there is an urgent need that an expenditure of moneys from the fund be used to update technology standards, the state commissioner may spend the moneys without convening the panel. In such instance, the state commissioner shall report that expenditure at the next meeting of the panel.

22.600(5) The panel shall create guidelines for loaning moneys from the fund to county commissioners for the updating of polling place technology. The guidelines shall be published on the state commissioner's website. The panel shall not approve funding for the purchase of e-pollbooks that are not certified by the state commissioner pursuant to 2025 Iowa Acts, House File 954, section 11, or Iowa Code section 49.29, unless the e-pollbook's certification has been waived by the state commissioner.

22.600(6) Before distributing or loaning funds, the panel shall consider the published guidelines, but may take additional factors into consideration. The panel shall not waive any information technology security standards~~, but may waive other requirements~~. A majority vote of the panel members present is sufficient to approve funding.

22.600(7) Before any funds from the revolving loan fund are provided for the acquisition of e-poll books, the e-poll book system shall conform to the security requirements within this chapter.

This rule is intended to implement ~~2017 Iowa Acts, House File 516, section 37~~ Iowa Code section 47.11.

ITEM 2. Amend rule 721—22.601(47) as follows:

721—22.601(47) Operational ~~features~~ requirements of e-poll books.

22.601(1) *Definitions.*

"E-poll book" is as defined in rule 721—22.1(52).

"Vendor," for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.601(2) *Operational ~~features~~ requirements.* When assessing applications for funding from the revolving loan fund established by ~~2017 Iowa Acts, House File 516, section 37~~ Iowa Code section 49.11, as implemented in rule 721—22.600(47), the e-poll book and polling place modernization panel shall consider whether the e-poll book sought includes the operational features described in this subrule. ~~Commissioners using only county funds for the purchase of e-poll book systems are not subject to the operational features described below, but are subject to all of the security requirements set forth in rule 721—22.602(47).~~ The panel shall consider:

a. Whether the e-poll book is able to accept a secure data file that imports voter registration data into the e-poll book application from the statewide voter registration system. This requirement may not be waived by the panel.

b. Whether the e-poll book is able to securely export data files that can be imported into the statewide voter registration system, including a file to update the voter activity portion of the statewide voter registration system.

c. Whether the e-poll book is able to scan the barcodes of driver's licenses, DOT-issued nonoperator identification cards, and the voter identification card issued pursuant to ~~2017 Iowa Acts, House File 516, section 18, to be codified at~~ Iowa Code section 48A.10A.

d. Whether the e-poll book is able to verify the voter against the felon database.

e. Whether the e-poll book is able to process, record, and export the complete range of possible voter registration updates available to voters under Iowa law. The state commissioner shall maintain a form that lists the possible updates that are required by this subrule.

f. Whether the e-poll book is able to complete and print the following forms:

(1) State of Iowa Official Voter Registration Form.

(2) Election Day Voter Registration Form, including Voter's Oath and Attester's Oath, if applicable.

(3) Provisional Ballot Form, including the State of Iowa Official Voter Registration Form and Statement to Person Casting a Provisional Ballot.

(4) Challenger's Statement.

(5) Affidavit of Voter Requesting Assistance.

~~**22.601(3)** *Certification.* A vendor providing an e-poll book platform in this state shall certify in writing to the state commissioner that the requirements of subrule 22.601(2) are met. If any of the requirements are not met, the vendor shall note the exceptions conspicuously.~~

This rule is intended to implement ~~2017 Iowa Acts, House File 516, section 37~~ Iowa Code section 47.11.

ITEM 3. Amend rule 721—22.602(47) as follows:

721—22.602(47) Security ~~features~~ requirements of e-poll books. All e-poll book systems in use in this state, including those funded by county moneys, shall conform to the following security standards.

22.602(1) *Definitions.*

"E-poll book" is as defined in rule 721—22.1(47).

"Secure," for purposes of this rule, means "encryption" as defined by Iowa Code section 715C.1(5).

"Vendor," for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.602(2) *Encryption of data at rest.* The e-poll book system shall ensure that all voter data is encrypted at rest. "Encrypted at rest" includes encryption of the whole hard drive, database, application data deemed confidential, and removable media. The data encryption keys shall be stored separately from the e-poll book hardware and software.

22.602(3) *Encryption of data in transit.* The e-poll book system shall ensure that all voter data is encrypted in transit via secure transfer protocols.

22.602(4) *Security updates.* The commissioner shall ensure that the computer maintains the most recent security updates available for the computer's operating system. The vendor shall ensure that the e-poll book software remains compatible with all security updates issued for the computer's operating system. An e-poll book system in use in Iowa shall not be installed on an operating system that is no longer supported by the developer.

22.602(5) *Authentication.* Every e-poll book system shall require authentication to the operating system and to the e-poll book application separately through a minimum of a username-password combination. A commissioner shall use a unique username-password combination for each precinct.

22.602(6) *Decommissioning.* At the time of decommissioning, the hard drive from the computer shall be destroyed by the owner of the hardware. This shall occur before the commissioner or vendor resells, gifts, repurposes, or otherwise disposes of the equipment. A record of the destruction shall be kept by the owner.

22.602(7) *Notification.* A vendor upon offering a new e-poll book platform, or upon making a change to the security ~~features~~ requirements of an existing e-poll book, shall notify the state commissioner of the ~~encryption and authentication standards utilized~~ changes in sufficient detail for the state commissioner to determine whether reasonable security features are in place to protect the e-poll book and related data.

This rule is intended to implement ~~2017 Iowa Acts, House File 516, section 37~~ Iowa Code sections 47.11 and 49.29.

ITEM 4. Adopt the following **new** rule 721—22.603(47):

721—22.603(47) Certification of e-poll books. All e-poll book systems in use in this state, including those funded by county moneys, shall conform to the following certification procedure.

22.603(1) *Definitions.*

"E-poll book" means the same as defined in rule 721—22.1(47).

"Vendor," for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.603(2) *Temporary certification application.*

a. A vendor providing or wanting to provide an e-poll book platform in this state may apply for certification on the form prescribed by the state commissioner. The vendor shall certify in writing to the state commissioner that the requirements of rules 721—22.601(47) and 721—22.602(47) are met. If any of the requirements are not met, the vendor shall note the exceptions conspicuously.

b. A vendor operating in this state on or after [the effective date of this rule] shall apply as provided above. Applications received for e-poll book versions currently operating in the state may be approved.

c. Upon adoption of the rule for permanent certification application, all vendors will need to reapply for certification within the time permitted by that rule to continue offering their products in the state.

This rule is intended to implement Iowa Code section 49.29.

ARC 9692C

CHIEF INFORMATION OFFICER, OFFICE OF THE[129]

Notice of Intended Action

Proposing rulemaking related to office organization and providing an opportunity for public comment

The Office of the Chief Information Officer (OCIO) hereby proposes to rescind Chapter 1, "Office Organization," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 8 and 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 8 and 17A.

Purpose and Summary

This chapter provided the historic statement required by Iowa Code chapter 17A concerning organization of the office. The chapter is no longer necessary now that OCIO is part of the Department of Management, so the chapter is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **129—Chapter 1**.

ARC 9693C

CHIEF INFORMATION OFFICER, OFFICE OF THE[129]

Notice of Intended Action

Proposing rulemaking related to public records and fair information practices and providing an opportunity for public comment

The Office of the Chief Information Officer (OCIO) hereby proposes to rescind Chapter 2, "Public Records and Fair Information Practices," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 8, 17A and 22.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 8, 17A and 22.

Purpose and Summary

This chapter provided direction to the OCIO in regard to public records and fair information practices. This chapter is no longer necessary now that OCIO is part of the Department of Management. The Department has its own chapter in this regard, so the chapter is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **129—Chapter 2**.

ARC 9694C

CHIEF INFORMATION OFFICER, OFFICE OF THE[129]

Notice of Intended Action

Proposing rulemaking related to petitions for rulemaking and providing an opportunity for public comment

The Office of the Chief Information Officer (OCIO) hereby proposes to rescind Chapter 3, "Petitions for Rule Making," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

This chapter provided guidance for filing petitions for rulemaking with the OCIO. This chapter is no longer necessary now that OCIO is part of the Department of Management, so the chapter is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **129—Chapter 3**.

ARC 9681C

CHIEF INFORMATION OFFICER, OFFICE OF THE[129]

Notice of Intended Action

Proposing rulemaking related to declaratory orders and providing an opportunity for public comment

The Office of the Chief Information Officer (OCIO) hereby proposes to rescind Chapter 4, "Declaratory Orders," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 8 and 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 8 and 17A.

Purpose and Summary

This chapter provided guidance on declaratory orders filed with the OCIO. Chapter 4 concerning declaratory orders is no longer necessary and is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **129—Chapter 4**.

ARC 9680C

CHIEF INFORMATION OFFICER, OFFICE OF THE[129]

Notice of Intended Action

Proposing rulemaking related to office procedure for rulemaking and providing an opportunity for public comment

The Office of the Chief Information Officer (OCIO) hereby proposes to rescind Chapter 5, "Office Procedure for Rule Making," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

This chapter provided guidance on OCIO office procedure for rulemaking. Chapter 5 concerning the OCIO procedure for rulemaking is no longer necessary and is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **129—Chapter 5**.

ARC 9682C

CHIEF INFORMATION OFFICER, OFFICE OF THE[129]

Notice of Intended Action

Proposing rulemaking related to waivers and providing an opportunity for public comment

The Office of the Chief Information Officer (OCIO) hereby proposes to rescind Chapter 7, "Waivers," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 8 and 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 8 and 17A.

Purpose and Summary

This chapter provides guidance on waivers from rules adopted by OCIO. Chapter 7 concerning waivers from rules adopted by OCIO is no longer necessary and is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **129—Chapter 7**.

ARC 9683C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to operations of city finance committee and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 1, "Operations of City Finance Committee," Iowa Administrative Code, and to adopt a new Chapter 1 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A and sections 384.13 through 384.22.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 384.13 through 384.22.

Purpose and Summary

The proposed chapter provides basic information about the committee to facilitate taxpayer interactions with the Committee.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn
Iowa Department of Management
1007 East Grand Ave, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 545—Chapter 1 and adopt the following **new** chapter in lieu thereof:

CHAPTER 1
OPERATIONS OF CITY FINANCE COMMITTEE

545—1.1(384) Purpose. To ensure that the proceedings of the city finance committee are conducted in an orderly manner and also to provide that the public is kept informed of actions taken by the city finance committee, the committee adopts the following rules.

545—1.2(384) Definitions. The following definitions apply to the rules of the city finance committee.

"Committee's mailing address" is Department of Management, 1007 East Grand Avenue, G13, Des Moines, Iowa 50319.

"Department" means the department of management.

"Director" means the director of the department.

"Fund" means a fiscal and accounting entity with a self-balancing set of accounts recording cash and other financial resources, together with all related liabilities and residual equities or balances, and changes therein that are segregated for the purpose of carrying on specific activities or attaining certain objectives in accordance with special regulations, obligations, or limitations.

"Fund transfer resolution" means a resolution of the city council that is to be passed to allow for transfers between funds. A fund transfer resolution is to be completed for all transfers between funds and will include a clear statement of reason or purpose for the transfer, the name of the fund from which the transfer is originating, the name of the fund into which the transfer is to be received, and the dollar amount to be transferred. For transfers of utility surpluses outlined in 545—subrule 2.4(5), the calculation proving the surplus will also be shown in the resolution. Intrafund transfers do not need a fund transfer resolution. Multiple transfers between funds may be approved in one resolution, so long as each transfer's purpose, originating fund or subfund, and receiving fund or subfund, and the amount of transferred dollars are separately identified. Fund transfer resolutions may also be included in budget or budget amendment adoption resolutions, so long as each transfer's purpose, originating fund or subfund and receiving fund or subfund, and the amount of transferred dollars are separately identified.

"Intrafund transfer" means a transfer between accounts or subfunds within a fund.

"Program" means any one of the following nine major functions of public service that the city finance committee directs a city to use in defining the city's program structure:

1. Public safety;
2. Public works;
3. Health and social services;
4. Culture and recreation;
5. Community and economic development;
6. General government;
7. Debt service;
8. Capital projects;
9. Business-type activities.

"Transfers between funds" means the transfer of amounts from one fund to another fund.

545—1.3(384) Membership. The selection, appointment and approval of members to the city finance committee are made as provided for in Iowa Code section 384.13. Names of designees will be given to the committee chairperson in writing by July 1 of each year, or promptly, if changed.

545—1.4(384) Organization and administration. The officers of the city finance committee will consist of a chairperson, a vice chairperson and a secretary.

1.4(1) *Chairperson.* The chairperson will be elected yearly to preside over the proceedings of the city finance committee. Upon a vacancy on the city finance committee, the chairperson will notify the director that a vacancy exists.

1.4(2) *Vice chairperson.* The vice chairperson serves in absence of the chairperson and can be assigned such other duties as the committee determines. The vice chairperson is elected yearly.

1.4(3) *Secretary.* The department will designate a secretary to serve as the support staff for the committee. The secretary is responsible for providing timely notice of meetings, publishing a meeting agenda in accordance with the Iowa Code, and keeping minutes of meetings.

545—1.5(384) Compensation. Committee members are to be compensated as provided by law.

545—1.6(384) Meeting. A meeting of the committee is to be held at the call of the director, the request of a majority of committee members, or upon an appeal of the director's decision. All meetings will be open to the public with the exception of any closed sessions of such meetings conducted in accordance with Iowa Code chapter 21.

545—1.7(384) Office location. All submissions to or requests of the committee should be made to the committee at the committee's mailing address during normal working hours.

545—1.8(384) Quorum and majority vote. A quorum consists of five members of the committee. All actions of the committee for promulgating rules as provided for by law need a minimum of five votes. All other actions of the committee can be approved by a simple majority vote of the members present at a meeting.

545—1.9(384) Order of business. The meetings of the city finance committee are to be presided over by the chairperson or the vice chairperson. Unless otherwise stipulated in these rules, Robert's Rules of Order are to be followed in conducting the business of the committee.

These rules are intended to implement Iowa Code sections 384.13 through 384.22.

ARC 9684C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to budget amendments and fund transfers and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 2, "Budget Amendments and Fund Transfers," Iowa Administrative Code, and to adopt a new Chapter 2 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 384.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 384.

Purpose and Summary

The proposed chapter provides basic administrative rules concerning budget amendments and rules addressing transfer of funds within a city budget.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 545—Chapter 2 and adopt the following **new** chapter in lieu thereof:

CHAPTER 2
BUDGET AMENDMENTS AND FUND TRANSFERS

PREAMBLE

Consistent with home rule legislation, the city finance committee encourages as much flexibility as possible in the municipal budget administration. At the same time, it is the responsibility of the city finance committee to impose those procedures and processes necessary to ensure adequate notice to citizens of proposed and adopted changes in the local budget and to provide an opportunity for citizen involvement in the reallocation process.

545—2.1(384,388) Appropriation of unanticipated amount. Budget amendments to the adopted city budget to permit the appropriation and expenditure of unencumbered and unanticipated balances or amounts anticipated to be available from sources other than property taxes but which have not been appropriated in the adopted budget will be prepared as provided in Iowa Code section 384.16 and are subject to protest as provided in Iowa Code section 384.19.

All adopted budget amendments to appropriate and expend unanticipated amounts are to be certified to the auditor of the county or counties where the city is located and to the director.

545—2.2(384,388) Transfers between programs. Except as specifically provided elsewhere in these rules, all appropriation transfers between programs are budget amendments and will be prepared as provided in Iowa Code section 384.16 and subject to protest as provided in Iowa Code section 384.19.

All adopted budget amendments to permit the transfer of adopted budget appropriations between programs are to be certified to the auditor of the county or counties where the city is located and to the director.

545—2.3(384,388) Transfers within programs. Transfers within programs are not budget amendments within the meaning of Iowa Code section 384.18. It is the responsibility of the governing body of each city to provide its own written rules for transfers within programs.

545—2.4(384,388) Fund transfers.

2.4(1) *General provisions.* All transfers of moneys between funds found in the city budget forms will be approved by a fund transfer resolution. Transfers between funds in one program are types of amendments that are not subject to preparation and adoption as provided in Iowa Code section 384.16 and are not subject to protest as provided in Iowa Code section 384.19, but such transfers will comply with the state laws regarding the funds and the following subrules.

2.4(2) *Debt service fund.* Except where specifically not allowed under state law, moneys may be transferred from any other city fund to the debt service fund to meet outstanding principal and interest. Such transfers are to be authorized by the original budget or a budget amendment that has been adopted as provided in Iowa Code section 384.16 and subject to protest as provided in Iowa Code section 384.19.

2.4(3) *Capital improvements reserve fund.* Except where specifically not allowed under state law, moneys may be transferred from any city fund to the capital improvements reserve fund for purposes specified in Iowa Code section 384.7. Such transfers are to be authorized by the original budget or a budget amendment adopted as provided in Iowa Code section 384.16 and subject to protest as provided in Iowa Code section 384.19.

2.4(4) *City utility fund and city enterprise fund.* Any governing body of a city utility, combined utility system, city enterprise, or combined city enterprise that has a surplus in its fund may transfer such surpluses to any other city fund, except the emergency fund, by resolution of the appropriate governing body. For the purposes of this subrule:

a. A surplus may exist only after all required transfers have been made to any restricted accounts in accordance with the terms and provisions of any revenue bonds of loan agreements relating to the utility or enterprise fund.

b. A "surplus" is defined as the cash balance in the operating account or the unrestricted net position calculated in accordance with GAAP, after adding back the net pension and other post-employment benefits liabilities and the related deferred inflows of resources and deducting the related deferred outflows of resources, in excess of:

(1) The amount of the expenses of disbursements for operating and maintaining the utility or enterprise for the preceding three months, and

(2) The amount necessary to make all required transfers to restricted accounts for the succeeding three months.

These rules are intended to implement Iowa Code chapters 384 and 388.

ARC 9685C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to budget forms and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 3, "Budget Forms," Iowa Administrative Code, and to adopt a new Chapter 3 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 384 and 388.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 384.13 through 384.22.

Purpose and Summary

This proposed chapter complies with the Iowa Code mandate of Iowa Code section 384.16 to have rules in place to prescribe forms used for city budgets.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 545—Chapter 3 and adopt the following **new** chapter in lieu thereof:

CHAPTER 3
BUDGET FORMS

545—3.1(384) Budget forms. The city finance committee may propose to the director forms to be used for public notice of estimates and for certifying the original budget or budget amendments.

This rule is intended to implement Iowa Code sections 384.13 through 384.22.

ARC 9686C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to employee benefits and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 4, "Employee Benefits," Iowa Administrative Code, and to adopt a new Chapter 4 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 384.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 384.

Purpose and Summary

The proposed chapter establishes basic obligations concerning allowable employee benefits and establishes the requirement that benefits be in the city budget.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 545—Chapter 4 and adopt the following **new** chapter in lieu thereof:

CHAPTER 4
EMPLOYEE BENEFITS

545—4.1(384) Definition. Employee benefits are defined as and limited to the following:

1. Employer's share of Federal Insurance Contribution Act (FICA).
2. Employer's share of Iowa Public Employees' Retirement System (IPERS).
3. Employer's share of police and fire retirement systems.
4. Employer's share of medical payments under Iowa Code chapters 410 and 411.
5. Retiree hospital/medical/prescription benefits pursuant to Iowa Code section 364.25.
6. Workers' compensation costs or insurance premiums.
7. Unemployment benefits.
8. Employer's share of employee benefit plan costs for employees and their dependents, which would include only:

- Hospital/medical/prescription benefits;
- Dental benefits;
- Disability insurance benefits;
- Life insurance benefits;
- Long-term insurance benefits;
- Vision benefits.

9. Deferred compensation programs for city managers, fire chiefs, and police chiefs who do not participate in either IPERS or the Municipal Fire and Police Retirement System of Iowa (MFPRSI).

10. Employee wellness programs that are a part of, or are included with, a hospital/medical/prescription benefit program or a health and fitness program for employees that is adopted by city council motion, resolution, ordinance or included in a document approved by the city council.

11. Employee assistance program providing free counseling for employees and their dependents.

12. Occupational Safety and Health Administration (OSHA)-required tests (e.g., pulmonary and heart tests).

13. Regularly scheduled, city-required, postemployment physicals for employees, police reserves and volunteer firefighters.

545—4.2(384) Mandatory procedures. These employee benefits will be budgeted in the city general fund up to the tax rate limit of that fund with the excess being budgeted in the trust and agency fund for those employees being paid from the city general fund:

1. Employer's share of FICA under Iowa Code section 97C.10.
2. Employer's share of IPERS under Iowa Code section 97B.9.

545—4.3(384) Optional procedures. These employee benefits may be budgeted in either the city general or city trust and agency fund for those employees being paid from the city general fund.

1. Employer's share of police and fire pension and retirement systems under Iowa Code chapters 410 and 411.
2. Employer's share of medical payments under Iowa Code sections 410.18 and 411.15.
3. Retiree hospital/medical/prescription benefits pursuant to Iowa Code section 364.25.
4. Workers' compensation costs or insurance premiums.
5. Unemployment benefits.
6. Employer's share of employee benefit plan costs for employees and their dependents, which would include only:

- Hospital/medical/prescription benefits;
- Dental benefits;
- Disability insurance benefits;
- Life insurance benefits;
- Long-term care insurance benefits;
- Vision benefits.

7. Deferred compensation programs for city managers, fire chiefs, and police chiefs who do not participate in either IPERS or MFPRSI.
8. Employee wellness programs that are a part of, or are included with, a hospital/medical/prescription benefit program or a health and fitness program for employees that is adopted by city council motion, resolution, ordinance or included in a document approved by the city council.
9. Employee assistance program providing free counseling for employees and their dependents.
10. OSHA-required tests (e.g., pulmonary and heart tests).
11. Regularly scheduled, city-required postemployment physicals for employees, police reserves and volunteer firefighters.

545—4.4(384) Budgeting—other than general fund and road use tax fund. The revenues and appropriations for employee benefits for those employees being paid from any fund other than the city general fund and the road use tax fund are to be budgeted in and paid from the fund from which the employee is being paid.

These rules are intended to implement Iowa Code section 384.15.

ARC 9688C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to law enforcement officer training reimbursement and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 5, "Petitions for Rule Making," to adopt a new Chapter 5, "Law Enforcement Officer Training Reimbursement," and to rescind Chapter 9, "Law Enforcement Officer Training Reimbursement," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

The Committee is proposing to restructure the Committee's rules and move the rules regarding law enforcement officer training reimbursement from Chapter 9 to Chapter 5.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

December 5, 2025
9 to 10 a.m.

Room G14
1007 East Grand Avenue
Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Adopt the following **new** 545—Chapter 5:

CHAPTER 5
LAW ENFORCEMENT OFFICER TRAINING REIMBURSEMENT

545—5.1(384) Eligible reimbursement. Cities and counties are eligible for reimbursement of law enforcement officer training costs for law enforcement officers who have resigned. Training costs for officers fired, retired, or disabled will not be eligible for reimbursement.

545—5.2(384) Reimbursable costs. Costs eligible for reimbursement include all necessary and actual training costs not otherwise recovered to comply with Iowa Code chapter 80B. To the extent funding is available, costs incurred for approved advanced law enforcement training are also eligible for reimbursement. Advanced law enforcement training costs are to be approved by the local governing body and deemed legitimate, necessary, and proper by the director.

Reimbursable training costs include mileage, food, lodging, tuition, compensation of the officer in training, and the compensation of a replacement officer while the officer is in training. Mileage, food, and lodging costs are reimbursable at the rates normally reimbursed by the claimant to other employees for work-related travel. Compensation of the officer in training and the replacement officer(s) includes wages and employer-paid payroll taxes, insurance, and pension contributions. However, the reimbursable compensation of the replacement officer(s) will not exceed the reimbursable compensation of the officer in training.

Other costs eligible for reimbursement include those necessitated by the training facility, such as training uniforms, supplies, or equipment that was paid for by the claimant and not returned to or used by the claimant after training.

545—5.3(384) Filing of claims. Claims for reimbursement are to be filed on forms prescribed by the director and obtainable from the department.

Claims for payment are to be filed with the department at the committee's mailing address. Claims need to be filed within 90 days after the officer has resigned. If a reasonable cause can be shown, the due date may be waived. Claims filed after May 15 of any fiscal year will be considered for reimbursement in the following fiscal year. No more than one claim may be submitted for each reimbursable expense.

Claims are to be signed by the mayor or chairperson of the board of supervisors and attested by the city clerk or county auditor.

545—5.4(384) Documentation. Claims for reimbursement of law enforcement officer training costs are to be accompanied by proper documentation. Such documentation may include copies of invoices, canceled checks, salary and benefits schedules and any other supporting documents deemed necessary by the city finance committee.

545—5.5(384) Reimbursement percentage. The amount of reimbursement is to be based on the length of service of the resigned officer after completion of law enforcement training as provided by statute.

545—5.6(384) Payment. Funds available for reimbursement will first be applied to approved claims for minimum law enforcement officer training as set forth in Iowa Code chapter 80B. If the proceeds of the fund are insufficient to reimburse the total amount of the approved claims made during the year, the reimbursements will be prorated. Any remaining funds will be applied to approved claims for advanced law enforcement training on a pro rata basis.

545—5.7(384) Officer rehired. In the event a resigned officer is rehired by the city or county within one year from the date of resignation, the total costs reimbursed to the city or county for law enforcement training of that officer will be refunded to the law enforcement officer training reimbursement funds. The reimbursement for training costs will be refunded within 90 days of the date of rehire and will be accompanied by a letter of explanation.

545—5.8(384) Decision appealed. A city or county may appeal a reimbursement decision by the director to the city finance committee. The appeal is to be submitted in writing within 60 days from the date of notification of a decision from the director. Appeals are to be filed with the committee at the committee's mailing address.

These rules are intended to implement Iowa Code section 384.15.

ITEM 2. Rescind and reserve **545—Chapter 9**.

ARC 9687C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to tax rate suspension appeal and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 6, "Declaratory Orders," to adopt a new Chapter 6, "Tax Rate Suspension Appeal," and to rescind Chapter 10, "Tax Rate Suspension Appeal," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 24.30.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 24.48.

Purpose and Summary

This proposed rulemaking seeks to rescind Chapter 10 and repromulgate a revised version of the chapter as Chapter 6. The rulemaking simplifies the chapter and relies on defined terms used throughout the City Finance Committee's proposed rulemakings published herein (IAB 11/12/25) for consistency and ease of reading. The revisions also comply with Executive Order 10 by removing all restrictive words and phrases.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Adopt the following **new** 545—Chapter 6:

CHAPTER 6
TAX RATE SUSPENSION APPEAL

545—6.1(24) Decision appealed. A city may appeal a tax rate suspension decision by the director of the department to the city finance committee. The appeal is to be submitted in writing no later than February 1 to the committee at the committee's mailing address.

This rule is intended to implement Iowa Code section 24.48.

ITEM 2. Rescind and reserve **545—Chapter 10**.

ARC 9689C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to uniform rules on agency procedure and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 7, "Agency Procedure for Rule Making," and to adopt a new Chapter 7, "Uniform Rules on Agency Procedure," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 17A.4.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 17A.4.

Purpose and Summary

The Committee is proposing to restructure the Committee's rules to adopt the Uniform Rules on Agency Procedure with any necessary changes. As such, the existing rules regarding agency procedure for rulemaking will be obsolete. The existing rules in Chapter 7 are proposed to be rescinded, and the Committee's implementation of the Uniform Rules on Agency Procedure are proposed to be promulgated in a new Chapter 7.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 545—Chapter 7 and adopt the following **new** chapter in lieu thereof:

CHAPTER 7
UNIFORM RULES ON AGENCY PROCEDURE

The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website.

545—7.1(17A,22) Fair information practices. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to fair information practices, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

7.1(1) In lieu of the words "(official or body issuing these rules)", insert "committee".

7.1(2) In lieu of the word "agency", insert "committee" unless further specified in this rule.

7.1(3) In lieu of the words "(insert agency head)", insert "chairperson of the committee".

7.1(4) In lieu of the words "(insert agency name and address)", insert "the committee at the committee's mailing address".

7.1(5) In lieu of the words "(insert customary office hours and, if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays, and legal holidays".

7.1(6) In lieu of the words "(specify time period)", insert "30 minutes".

7.1(7) Delete the sentence "(An agency wishing to deal with search fees authorized by law should do so here.)".

7.1(8) In lieu of the words "(designate office)", insert "the committee's secretary".

7.1(9) In lieu of the words "(and, where applicable, the time period during which the record may be disclosed)", insert "and, where applicable, the time period during which the record may be disclosed".

7.1(10) In lieu of the sentence "(Additional requirements may be necessary for special classes of records.)", insert "Additional obligations may be necessary for special classes of records."

7.1(11) Delete the sentence "(Each agency should revise its forms to provide this information.)"

545—7.2(17A,22) Additional fair information practices—uses and disclosures of information.

7.2(1) *General.* Committee records are open for public inspection and copying unless otherwise provided by applicable law.

7.2(2) *Uses and disclosures of individually identifiable information.* To the extent allowed by law, uses or disclosures of confidential records may occur with or without the consent of the subject. Types of uses or disclosures that occur without the subject's consent include but are not necessarily limited to the following:

a. Use or disclosure for a routine use in relation to the work of the committee as long as such use or disclosure is made subject to the same confidentiality obligations imposed on the committee.

b. Use or disclosure for statistical research purposes or reporting as long as the information is deidentified in advance.

c. Use or disclosure for civil or criminal law enforcement activities to the extent authorized by law.

d. Disclosure to an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual.

e. Disclosure to the legislative services agency under Iowa Code section 2A.3.

f. Use or disclosure in the course of employee disciplinary proceedings.

g. Use or disclosure in response to a court order or subpoena.

7.2(3) *Complaints to public officials.* A letter from a subject of a confidential record held by the committee to a public official that seeks the official's intervention on behalf of the subject in a matter that involves the committee will, to the extent permitted by law, be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

7.2(4) *Release to subject.* The subject of a confidential record may submit a request to review confidential records about that person. However, the committee need not release the record to the subject to the extent that the record is confidential under applicable law. Records that may be declared confidential include but are not necessarily limited to records that are predecisional draft documents, peace officers' investigative reports, records that are subject to the attorney-client privilege, and records that are subject to the attorney work product doctrine. When a record has multiple identifiable subjects with interest in the confidentiality of the record, the committee may take reasonable steps to protect confidential information relating to another subject.

545—7.3(17A) Petitions for rulemaking. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to petitions for rulemaking, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

7.3(1) In lieu of the word "agency", insert "committee".

7.3(2) In lieu of the words "(designate office)", insert "committee's mailing address".

7.3(3) In lieu of the words "designate official by full title and address", insert "chairperson of the committee at the committee's mailing address".

545—7.4(17A) Declaratory orders. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to declaratory orders, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

7.4(1) In lieu of the words "designate agency", insert "committee" unless further specified in this rule.

7.4(2) In lieu of the words "designate office", insert "the committee's mailing address".

7.4(3) Delete the sentence "(An agency may wish to describe here a simplified alternative petition form that would be more appropriate for some members of its clientele in light of their particular circumstances.)"

7.4(4) In lieu of the words "Within ____ days (15 or less)" found in rule X.2, insert "Within 15 days".

7.4(5) In lieu of the words "within ____ days of the filing of a petition" in rule X.3(1), insert "within 15 days of the filing of a petition".

7.4(6) In lieu of the words "(after time for notice under X.2(17A))", insert "15 days following receipt of notice from the committee that a petition has been filed".

7.4(7) In lieu of the words "(agency name)", insert "committee".

7.4(8) In lieu of the words "(specify office and address)", insert "the committee at the committee's mailing address".

7.4(9) In lieu of the words "(designate agency head)", insert "the chairperson of the committee".

7.4(10) In lieu of the words "(uniform rule on contested cases X.12(17A))" and "(contested case uniform rule X.2(17A))", insert "the committee's contested case rule".

7.4(11) Delete the sentence "(The agency may specify any provisions of Iowa Code sections 17A.10 through 17A.18 on contested case proceedings to apply to proceedings for declaratory orders.)"

7.4(12) Delete the sentence "(Where the agency's experience enables it to define in advance other specific reasons for refusing to issue a declaratory order, it should include them here.)"

7.4(13) In lieu of the words "(who consent to be bound)", insert "who consent to be bound".

7.4(14) At the end of rule X.12, add the following: "The final ruling of the committee is subject to review pursuant to the committee's contested case rules."

545—7.5(17A) Committee procedure for rulemaking. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to agency procedure for rulemaking, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

7.5(1) In lieu of the words "(commission, board, council, director)", insert "committee".

7.5(2) In lieu of the word "agency", insert "committee", unless further specified in this rule.

7.5(3) In lieu of the words "(specify time period)", insert "one calendar year".

7.5(4) In lieu of the words "(identify office and address)", insert "the secretary at the committee's mailing address".

7.5(5) In lieu of the words "(designate office and telephone number)", insert "the secretary at 515.281.3705".

7.5(6) In lieu of the words "(designate office)", insert "the committee's mailing address" unless further specified in this rule.

7.5(7) Delete rule X.10(17A).

7.5(8) In lieu of the words "(specify the office and address)", insert "the committee's mailing address".

7.5(9) In lieu of the words "(agency head)", insert "chairperson of the committee".

7.5(10) Delete the sentences "(Alternatively, the agency can maintain the file indefinitely.)" and "(*NOTE: Alternatively to X.13(2)*"j"* and the amendment of X.13(4), an agency could keep a separate file of significant written criticisms to rules and maintain those for five years.)"

7.5(11) In lieu of the words "(at actual cost)", insert "at actual cost".

545—7.6(17A) Contested cases. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to contested cases, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

7.6(1) In lieu of the words "(agency name)" or "agency", insert "committee".

7.6(2) In lieu of the words "(designate official)", insert "chairperson".

7.6(3) In lieu of the words "(specify rule number)", insert "rule".

7.6(4) Delete paragraph X.5(1)*"e"*.

7.6(5) Delete the words "(e.g., agency head, members of multimembered agency head, administrative law judge from the department of inspections and appeals)".

7.6(6) Delete the words "(or such other time period the agency designates)".

7.6(7) In lieu of the words "(or its designee)", insert "or its designee".

7.6(8) Delete the sentence "(The agency may specify other good cause by rule.)".

7.6(9) Delete subrule X.6(4).

7.6(10) In lieu of the words "(specify office and address)", insert "the committee's secretary at the committee's mailing address".

7.6(11) In lieu of the words "(designate office)", insert "committee's secretary".

7.6(12) Delete the words "(or other time period designated by the agency)".

7.6(13) In lieu of the words "Iowa Rule of Civil Procedure 237", insert "Iowa Rules of Civil Procedure, Division IX, Subdivision D".

7.6(14) In lieu of the words "(45 days)", insert "45 days".

7.6(15) In lieu of the words "(15 days)", insert "15 days".

7.6(16) In lieu of the words "(20 days)", insert "20 days".

7.6(17) Delete the words "(or other period of time specified by statute or rule)".

7.6(18) Delete the words "(or other time specified by the agency)".

7.6(19) In lieu of the words "(but, unless the defaulting party has appeared, it cannot exceed the relief demanded)", insert "but, unless the defaulting party has appeared, it cannot exceed the relief demanded".

7.6(20) In lieu of the words "(or disclosed)", insert "or disclosed".

7.6(21) In lieu of the words "(agency to designate person to whom violations should be reported)", insert "the chairperson of the committee".

7.6(22) In lieu of the words "(board, commission, director)", insert "committee" unless further specified in this rule.

7.6(23) In lieu of the words "(of the presiding officer)", insert "of the presiding officer".

7.6(24) In lieu of the words "(the agency) (or a quorum of the agency)", insert "the committee".

7.6(25) In lieu of the words "(board, commission, director, as appropriate)", insert "committee".

These rules are intended to implement Iowa Code chapter 17A.

ARC 9690C

CITY FINANCE COMMITTEE[545]

Notice of Intended Action

Proposing rulemaking related to public records and fair information practices and providing an opportunity for public comment

The City Finance Committee hereby proposes to rescind Chapter 8, "Public Records and Fair Information Practices," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 17A.7 and 22.11.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 17A.7 and 22.11.

Purpose and Summary

This chapter is proposed to be rescinded in favor of the Committee's adoption of the Uniform Rules on Agency Procedure.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **545—Chapter 8**.

ARC 9675C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to general provisions and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 1, "Definitions," and to adopt a new Chapter 1, "General Provisions," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 333A.4(6).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 333A.2.

Purpose and Summary

A reduction and restructuring of the rules concerning the County Finance Committee is proposed to make the rules more efficient and accessible. The rules will be updated by removing language restated from the Iowa Code, removing restrictive words and phrases, and relocating rules currently located across five chapters into a single chapter. Chapter 1 will be rescinded, and essential rules from 547—Chapters 2 through 5 will be moved to proposed Chapter 1. This change aims to consolidate and simplify the rules to improve efficiency and clarity.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 547—Chapter 1 and adopt the following **new** chapter in lieu thereof:

CHAPTER 1
GENERAL PROVISIONS

547—1.1(333A) Definitions.

"Committee" means the county finance committee established in Iowa Code section 333A.2.

"Committee's mailing address" is Iowa Department of Management, State Capitol, Des Moines, Iowa 50319.

"County budget" means the budget adopted by the board of supervisors pursuant to Iowa Code chapter 331.

"County official" means members of the committee referred to as "county official," which may be either a county officer designated in Iowa Code section 39.17 or a member of the board of supervisors as designated in Iowa Code section 39.18.

547—1.2(333A) Organization and administration.

1.2(1) *Purpose.* The purpose of the county finance committee is to administer the provisions of Iowa Code section 333A.2 and to make recommendations to the governor, the general assembly, and county officials concerning county budgets and finance.

1.2(2) *Membership.* The selection, appointment, and approval of the county finance committee members are made as provided in Iowa Code section 333A.2.

1.2(3) *Officers.* The officers of the committee consist of chairperson and vice chairperson.

1.2(4) *Subcommittees.* The committee may establish temporary subcommittees to research and investigate items of business for the committee.

1.2(5) *Office location.* The director of the department of management provides office space, staff assistance, and necessary supplies and equipment as provided by law.

547—1.3(333A) Meetings.

1.3(1) *Organizational meeting.* The organizational meeting of the committee will be held at the call of and at a place designated by the chairperson. The officers serve until their successors are appointed.

1.3(2) *Other meetings.* Meetings may be called by the chairperson of the committee or a majority of its members.

1.3(3) *Conduct of meetings.* Meetings of the committee will be conducted in accordance with Robert's Rules of Order insofar as not incompatible with the laws of the state of Iowa governing this committee or its own resolutions as to its conduct.

547—1.4(333A) Secretary's duties.

1.4(1) *Notice of meeting.* Notice will be given of the time and place of each meeting by the committee's secretary.

1.4(2) *Meeting minutes.* Minutes will be kept of all proceedings of each meeting by the committee's secretary, and the minutes will constitute the official record of all committee actions.

1.4(3) *Mailing list.* A current list of committee members, including the members' addresses, telephone numbers and terms of office, will be maintained by the secretary.

547—1.5(333A) Compensation. Committee members are to be compensated as provided in Iowa Code section 333A.3.

547—1.6(333A) Studies and reports. At least five members of the committee are needed to approve any guidelines, comments, recommendations and proposed legislation.

547—1.7(333A) County budgets. County budgets will be prepared in accordance with the provisions of Iowa Code section 331.424.

547—1.8(333A) Annual financial reports. County annual financial reports will be prepared in accordance with the provisions of Iowa Code section 331.403.

These rules are intended to implement Iowa Code section 333A.2.

ARC 9676C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to uniform rules on agency procedure and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 2, "Organization and Administration," to adopt a new Chapter 2, "Uniform Rules on Agency Procedure," and to rescind Chapter 6, "Petitions for Rule Making," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

As part of the Department's review of administrative rules pursuant to Executive Order 10, the Department proposes to rescind all rules addressing the standard Administrative Procedure Act obligations under Iowa Code chapter 17A and adopt the Uniform Rules on Agency Procedure published by the Legislative Services Agency on the General Assembly's website. This greatly simplifies the Committee's administrative rules and is expected to result in more consistent treatment of such issues across the Department's administrative rules. This proposed rulemaking rescinds Chapter 6 and then repromulgates the Uniform Rules on Agency Procedure as new Chapter 2.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Adopt the following **new** 547—Chapter 2:

CHAPTER 2
UNIFORM RULES ON AGENCY PROCEDURE

The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website.

547—2.1(17A,22) Fair information practices. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to fair information practices, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

2.1(1) In lieu of the words "(official or body issuing these rules)", insert "committee".

2.1(2) In lieu of the word "agency", insert "committee", unless further specified in this rule.

2.1(3) In lieu of the words "(insert agency head)", insert "chairperson of the committee".

2.1(4) In lieu of the words "(insert agency name and address)", insert "the committee at the committee's mailing address".

2.1(5) In lieu of the words "(insert customary office hours and, if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays, and legal holidays".

2.1(6) In lieu of the words "(specify time period)", insert "30 minutes".

2.1(7) Delete the sentence "(An agency wishing to deal with search fees authorized by law should do so here.)"

2.1(8) In lieu of the words "(designate office)", insert "the committee's secretary".

2.1(9) In lieu of the words "(and, where applicable, the time period during which the record may be disclosed)", insert "and, where applicable, the time period during which the record may be disclosed".

2.1(10) In lieu of the sentence "(Additional requirements may be necessary for special classes of records.)", insert "Additional obligations may be necessary for special classes of records."

2.1(11) Delete the sentence "(Each agency should revise its forms to provide this information.)"

547—2.2(17A,22) Additional fair information practices—uses and disclosures of information.

2.2(1) *General.* Committee records are open for public inspection and copying unless otherwise provided by applicable law.

2.2(2) *Uses and disclosures of individually identifiable information.* To the extent allowed by law, uses or disclosures of confidential records may occur with or without the consent of the subject. Types of

uses or disclosures that occur without the subject's consent include but are not necessarily limited to the following:

a. Use or disclosure for a routine use in relation to the work of the committee as long as such use or disclosure is made subject to the same confidentiality obligations imposed on the committee.

b. Use or disclosure for statistical research purposes or reporting as long as the information is deidentified in advance.

c. Use or disclosure for civil or criminal law enforcement activities to the extent authorized by law.

d. Disclosure to an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual.

e. Disclosure to the legislative services agency under Iowa Code section 2A.3.

f. Use or disclosure in the course of employee disciplinary proceedings.

g. Use or disclosure in response to a court order or subpoena.

2.2(3) *Complaints to public officials.* A letter from a subject of a confidential record held by the committee to a public official that seeks the official's intervention on behalf of the subject in a matter that involves the committee will, to the extent permitted by law, be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

2.2(4) *Release to subject.* The subject of a confidential record may submit a request to review confidential records about that person. However, the committee need not release the record to the subject to the extent that the record is confidential under applicable law. Records that may be declared confidential include but are not necessarily limited to records that are predecisional draft documents, peace officers' investigative reports, records that are subject to the attorney-client privilege, and records that are subject to the attorney work product doctrine. When a record has multiple identifiable subjects with interest in the confidentiality of the record, the committee may take reasonable steps to protect confidential information relating to another subject.

547—2.3(17A) Petitions for rulemaking. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to petitions for rulemaking, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

2.3(1) In lieu of the word "agency", insert "committee".

2.3(2) In lieu of the words "(designate office)", insert "committee's mailing address".

2.3(3) In lieu of the words "designate official by full title and address", insert "chairperson of the committee at the committee's mailing address".

547—2.4(17A) Declaratory orders. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to declaratory orders, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

2.4(1) In lieu of the words "designate agency", insert "committee" unless further specified in this rule.

2.4(2) In lieu of the words "designate office", insert "the committee's mailing address".

2.4(3) Delete the sentence "(An agency may wish to describe here a simplified alternative petition form that would be more appropriate for some members of its clientele in light of their particular circumstances.)"

2.4(4) In lieu of the words "Within ____ days (15 or less)" found in rule X.2, insert "Within 15 days".

2.4(5) In lieu of the words "within ____ days of the filing of a petition" in rule X.3(1), insert "within 15 days of the filing of a petition".

2.4(6) In lieu of the words "(after time for notice under X.2(17A))", insert "15 days following receipt of notice from the committee that a petition has been filed".

2.4(7) In lieu of the words "(agency name)", insert "committee".

2.4(8) In lieu of the words "(specify office and address)", insert "the committee at the committee's mailing address".

2.4(9) In lieu of the words "(designate agency head)", insert "the chairperson of the committee".

2.4(10) In lieu of the words "(uniform rule on contested cases X.12(17A))" and "(contested case uniform rule X.2(17A))", insert "the committee's contested case rule".

2.4(11) Delete the sentence "(The agency may specify any provisions of Iowa Code sections 17A.10 through 17A.18 on contested case proceedings to apply to proceedings for declaratory orders.)"

2.4(12) Delete the sentence "(Where the agency's experience enables it to define in advance other specific reasons for refusing to issue a declaratory order, it should include them here.)"

2.4(13) In lieu of the words "(who consent to be bound)", insert "who consent to be bound".

2.4(14) At the end of rule X.12, add the following: "The final ruling of the committee is subject to review pursuant to the committee's contested case rules."

547—2.5(17A) Committee procedure for rulemaking. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to agency procedure for rulemaking, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

2.5(1) In lieu of the words "(commission, board, council, director)", insert "committee".

2.5(2) In lieu of the word "agency", insert "committee", unless further specified in this rule.

2.5(3) In lieu of the words "(specify time period)", insert "one calendar year".

2.5(4) In lieu of the words "(identify office and address)", insert "the secretary at the committee's mailing address".

2.5(5) In lieu of the words "(designate office and telephone number)", insert "the secretary at 515.281.3322".

2.5(6) In lieu of the words "(designate office)", insert "the committee's mailing address" unless further specified in this rule.

2.5(7) Delete rule X.10(17A).

2.5(8) In lieu of the words "(specify the office and address)", insert "the committee's mailing address".

2.5(9) In lieu of the words "(agency head)", insert "chairperson of the committee".

2.5(10) Delete the sentences "(Alternatively, the agency can maintain the file indefinitely.)" and "(*NOTE: Alternatively to X.13(2)*"j"* and the amendment of X.13(4), an agency could keep a separate file of significant written criticisms to rules and maintain those for five years.)"

2.5(11) In lieu of the words "(at actual cost)", insert "at actual cost".

547—2.6(17A) Contested cases. The committee hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to contested cases, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

2.6(1) In lieu of the words "(agency name)" or "agency", insert "committee".

2.6(2) In lieu of the words "(designate official)", insert "chairperson".

2.6(3) In lieu of the words "(specify rule number)", insert "rule".

2.6(4) Delete paragraph X.5(1)*"e"*.

2.6(5) Delete the words "(e.g., agency head, members of multimembered agency head, administrative law judge from the department of inspections and appeals)".

2.6(6) Delete the words "(or such other time period the agency designates)".

2.6(7) In lieu of the words "(or its designee)", insert "or its designee".

2.6(8) Delete the sentence "(The agency may specify other good cause by rule.)"

2.6(9) Delete subrule X.6(4).

2.6(10) In lieu of the words "(specify office and address)", insert "the committee's secretary at the committee's mailing address".

2.6(11) In lieu of the words "(designate office)", insert "committee's secretary".

2.6(12) Delete the words "(or other time period designated by the agency)".

2.6(13) In lieu of the words "Iowa Rule of Civil Procedure 237", insert "Iowa Rules of Civil Procedure, Division IX, Subdivision D".

2.6(14) In lieu of the words "(45 days)", insert "45 days".

2.6(15) In lieu of the words "(15 days)", insert "15 days".

2.6(16) In lieu of the words "(20 days)", insert "20 days".

2.6(17) Delete the words "(or other period of time specified by statute or rule)".

2.6(18) Delete the words "(or other time specified by the agency)".

2.6(19) In lieu of the words "(but, unless the defaulting party has appeared, it cannot exceed the relief demanded)", insert "but, unless the defaulting party has appeared, it cannot exceed the relief demanded".

2.6(20) In lieu of the words "(or disclosed)", insert "or disclosed".

2.6(21) In lieu of the words "(agency to designate person to whom violations should be reported)", insert "the chairperson of the committee".

2.6(22) In lieu of the words "(board, commission, director)", insert "committee" unless further specified in this rule.

2.6(23) In lieu of the words "(of the presiding officer)", insert "of the presiding officer".

2.6(24) In lieu of the words "(the agency) (or a quorum of the agency)", insert "the committee".

2.6(25) In lieu of the words "(board, commission, director, as appropriate)", insert "committee".

These rules are intended to implement Iowa Code chapter 17A.

ITEM 2. Rescind and reserve **547—Chapter 6**.

ARC 9674C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to studies and reports and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 3, "Studies and Reports," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 333A.4(6).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 333A.2.

Purpose and Summary

The Committee is proposing to restructure 547—Chapters 2 through 5 and move the rules into 547—Chapter 1, remove unnecessary language that merely restates the Iowa Code, and remove restrictive words identified in Executive Order 10 in order to improve accessibility and clarity of the rules. As part of this restructure, Chapter 3 is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **547—Chapter 3**.

ARC 9691C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to county budgets and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 4, "County Budgets," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 331.434, 331.435 and 333A.4(6).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 331.434 and 331.435.

Purpose and Summary

The Committee is proposing to restructure 547—Chapters 2 through 5 and move the rules into 547—Chapter 1, remove unnecessary language that merely restates the Iowa Code, and remove restrictive words identified in Executive Order 10 in order to improve accessibility and clarity of the rules. As part of this restructure, Chapter 4 is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **547—Chapter 4**.

ARC 9677C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to annual financial reports and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 5, "Annual Financial Reports," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 333A.4(6).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 333A.4.

Purpose and Summary

The Committee is proposing to restructure 547—Chapters 2 through 5 and move the rules into 547—Chapter 1, remove unnecessary language that merely restates the Iowa Code, and remove restrictive words identified in Executive Order 10 in order to improve accessibility and clarity of the rules. As part of this restructure, Chapter 5 is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **547—Chapter 5**.

ARC 9662C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to declaratory orders and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 7, "Declaratory Orders," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

The Committee is proposing to rescind Chapter 7 as part of its adoption of the Uniform Rules on Agency Procedure, which are addressed in a separate Notice herein (IAB 11/12/25).

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **547—Chapter 7**.

ARC 9678C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to agency procedure for rulemaking and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 8, "Agency Procedure for Rule Making," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

The Committee is proposing to rescind Chapter 8 as part of its adoption of the Uniform Rules on Agency Procedure, which are addressed in a separate Notice herein (IAB 11/12/25).

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **547—Chapter 8**.

ARC 9679C

COUNTY FINANCE COMMITTEE[547]

Notice of Intended Action

Proposing rulemaking related to public records and fair information practices and providing an opportunity for public comment

The County Finance Committee hereby proposes to rescind Chapter 9, "Public Records and Fair Information Practices," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

The Committee is proposing to rescind Chapter 9 as part of its adoption of the Uniform Rules on Agency Procedure, which are addressed in a separate Notice herein (IAB 11/12/25).

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 9, 2025. A public hearing was held on the following date(s):

- August 1, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Management for a waiver of the discretionary provisions, if any.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 5, 2025. Comments should be directed to:

Brad Horn, General Counsel
Department of Management
1007 East Grand Avenue, Room G13
Des Moines, Iowa 50319
Phone: 515.414.6187
Email: brad.horn@dom.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa
December 5, 2025 9 to 10 a.m.	Room G14 1007 East Grand Avenue Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **547—Chapter 9**.

ARC 9670C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to the seed investor tax credit program and providing an opportunity for public comment

The Economic Development Authority (Authority) hereby proposes to adopt new Chapter 114, "Seed Investor Tax Credit Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 15.106A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2025 Iowa Acts, Senate File 657.

Purpose and Summary

The Authority proposes to adopt a new Chapter 114. The proposed chapter describes the policies and procedures applicable to the Seed Investor Tax Credit program, available pursuant to Iowa Code chapter 15E, subchapter IV as enacted by 2025 Iowa Acts, Senate File 657. The program is designed to encourage early-stage investments in innovative Iowa businesses in key growth sectors, including advanced manufacturing, bioscience, finance and insurance, and technology.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025. A public hearing was held on the following date(s):

- September 23, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa beyond that of the legislation it is intended to implement.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Authority for a waiver of the discretionary provisions, if any, pursuant to 261—Chapter 199.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on December 4, 2025. Comments should be directed to:

Lisa Connell
Iowa Economic Development Authority
1963 Bell Avenue, Suite 200
Des Moines, Iowa 50315
Phone: 515.348.6163
Email: lisa.connell@iowaeda.com

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)"b," an oral presentation regarding this rulemaking may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Adopt the following **new** 261—Chapter 114:

CHAPTER 114
SEED INVESTOR TAX CREDIT PROGRAM

261—114.1(15E) Definitions. For purposes of this chapter, unless the context otherwise requires:

"Affiliate" means the same as defined in Iowa Code section 15E.26 as enacted by 2025 Iowa Acts, Senate File 657.

"Authority" means the economic development authority created in Iowa Code section 15.105.

"Board" means the members of the economic development authority appointed by the governor and in whom the powers of the authority are vested pursuant to Iowa Code section 15.105.

"Controlling equity interest" means ownership of more than 50 percent of the outstanding equity interests of a corporation, partnership, limited liability company, or trust.

"Convertible debt" means debt that may be converted to equity at the option of the debt holder but has not yet been converted.

"Director" means the director of the authority.

"Eligible investor" means an investor making an investment that is eligible for a tax credit pursuant to this chapter and Iowa Code chapter 15E, subchapter IV as enacted by 2025 Iowa Acts, Senate File 657.

"Equity" means common or preferred corporate stock or warrants to acquire such stock, membership interests in limited liability companies, or partnership interests in partnerships. Equity shall be limited to securities or interests acquired only for cash and shall not include securities or interests acquired at any time for services, contributions of property other than cash, convertible debt, or any other noncash consideration.

"Full-time equivalent employee" means a non-part-time position for the number of hours or days per week considered to be full-time work for the kind of service or work performed for an employer. Typically, a full-time equivalent position requires 2,080 hours of work in a calendar year, including all paid holidays, vacations, sick time, and other paid leave.

"Investment" means the same as defined in Iowa Code section 15E.26 as enacted by 2025 Iowa Acts, Senate File 657.

"Investor" means the same as defined in Iowa Code section 15E.26 as enacted by 2025 Iowa Acts, Senate File 657.

"Management control" means holding more than 50 percent of the voting power on any board of directors or trustees, any management committee, or any other group managing a corporation, partnership, limited liability company, or trust.

"Person" means an individual, corporation, limited liability company, business trust, estate, trust, partnership or association, or any other legal entity.

"Principal" means any current or prospective officer, director, or owner.

"Program" means the seed investor tax credit program administered pursuant to this chapter and Iowa Code chapter 15E, subchapter IV as enacted by 2025 Iowa Acts, Senate File 657.

"Qualifying business" means the same as defined in Iowa Code section 15E.26 as enacted by 2025 Iowa Acts, Senate File 657.

"Rural area" means the same as defined in Iowa Code section 15E.26 as enacted by 2025 Iowa Acts, Senate File 657.

"Urban area" means the same as defined in Iowa Code section 15E.26 as enacted by 2025 Iowa Acts, Senate File 657.

261—114.2(15E) Certification of qualifying businesses.

114.2(1) *Eligibility for certification as a qualifying business.* A business shall meet all of the criteria in Iowa Code section 15E.28 as enacted by 2025 Iowa Acts, Senate File 657, to be eligible for certification as a qualifying business.

114.2(2) *Length of business operations.* For the purposes of determining whether a business has been in operation for five years or less as required by Iowa Code section 15E.28(2)*"b"* as enacted by 2025 Iowa Acts, Senate File 657, the authority will consider the following factors:

a. The date of incorporation or organization;

b. The date on which the business began the sale of goods or services;

c. The date on which the business first hired employees;

d. The date of execution of business contracts; and

e. Any other information that indicates the date on which the business began materially engaging in commercial activity.

114.2(3) *Application for certification.* A qualifying business shall apply to the authority for certification as a qualifying business as prescribed by the authority. The application for certification will include the following information:

a. A description of the general nature of the business's operations.

b. The location of the principal business operations, any other business locations, and the number of employees at each of the business's locations.

c. The date on which the business was formed and the date on which the business commenced operations based on the factors identified in subrule 114.2(2).

d. Verification that the business has at least one full-time equivalent employee.

e. Evidence that the business's primary operations are in a qualifying industry pursuant to Iowa Code section 15E.28(2)*"d"* as enacted by 2025 Iowa Acts, Senate File 657. Such evidence may include but is not limited to whether the business has a North American industry classification system (NAICS) number aligned with the relevant industries as determined by the authority. Businesses with other NAICS numbers will be required to document to the authority's satisfaction that the business is primarily engaged in an applicable industry identified in Iowa Code section 15E.28(2)*"d"* as enacted by 2025 Iowa Acts, Senate File 657, based on factors including but not limited to sources of revenue and customer base. For the purposes of determining whether the business is primarily engaged in the provision of services that require a professional license, "services requiring a professional license" includes but is not limited to the professions listed in Iowa Code section 496C.2.

f. Documentation of the ownership, affiliates, and principals of the business sufficient to demonstrate the business is an independent organization that is not part of, or an affiliate of, a business that is not a qualifying business and to demonstrate that the business has at least two investors for the purposes of establishing its eligibility pursuant to Iowa Code section 15E.28(2)*"h"*(2) as enacted by 2025 Iowa Acts, Senate File 657.

g. A description of the manner in which the business satisfies the business experience requirements set forth in Iowa Code section 15E.28(2)*"f"* as enacted by 2025 Iowa Acts, Senate File 657.

h. A balance sheet that reflects the qualifying business's assets, liabilities, and owners' equity as of the close of the most recent month or quarter.

i. The names, addresses, shares or equity interests issued, consideration paid for the shares or equity interests, and estimated amounts of tax credits through the program of all shareholders or equity holders and the date on which the investment was made as well as documentation of any binding investment commitments made prior to application for certification. An agreement for convertible debt may be considered a binding investment commitment for the purposes of this paragraph.

j. A signed statement from an officer, director, manager, member, or general partner of the qualifying business certifying the accuracy of the information provided.

k. Any other information the authority may reasonably require to determine the business's eligibility for certification as a qualifying business and its investors' eligibility to receive tax credits or to allow the authority to estimate demand for tax credits.

114.2(4) *Authority review and notice of certification.*

a. Upon the authority's receipt of the information and documentation necessary to demonstrate satisfaction of the criteria set forth in Iowa Code section 15E.28 as enacted by 2025 Iowa Acts, Senate File 657, the authority shall, within a reasonable period of time, determine whether a business shall be certified as a qualifying business and, if applicable, issue written notification to the qualifying business that such business has been certified with the authority for the purpose of issuing investment tax credits. The authority will indicate in its written notice the first date investments are eligible for a tax credit based on the date of application for certification and the date the authority expects the certification to expire based on the date the business began operations. If the authority determines a business should not be certified, the authority shall issue written notification to the business of the denial of certification and provide the reasons why the business was not certified.

b. Prior to issuance of the written notification pursuant to paragraph 114.2(4)*"a,"* a qualifying business shall pay a nonrefundable application fee of $200 to the authority.

c. Following written notification of certification, a certified qualifying business shall enter into an agreement with the authority reflecting the terms of certification.

114.2(5) *Revocation and expiration of certification.*

a. A certified qualifying business shall provide any information the authority may reasonably request to confirm the business's continued eligibility for certification as a qualifying business and the eligibility of its investors to receive tax credits or to allow the authority to estimate demand for tax credits.

b. If a qualifying business fails to meet or maintain any requirement set forth in this chapter and in Iowa Code chapter 15E, subchapter IV as enacted by 2025 Iowa Acts, Senate File 657, the authority shall revoke the business's certification as a qualifying business by issuing written notice of revocation to the business. The notice will identify the last date on which the business was eligible to be certified as a qualifying business. Investments made after the identified date will not be eligible for a tax credit.

c. If a business continues to satisfy all eligibility requirements until it has been in operation for more than five years, the business's certification will expire on the date identified as the expected date of expiration pursuant to paragraph 114.2(4)*"a."* Investments made after the identified date will not be eligible for a tax credit.

d. The authority shall rescind any tax credit certificates issued to taxpayers for investments made after the date on which the business's certification was revoked or expired and shall notify the department of revenue that it has done so. A tax credit certificate that has been rescinded by the authority shall be null and void, and the department of revenue will not accept the tax credit certificate.

114.2(6) *Reporting.*

a. A certified qualifying business shall report new equity interests or transfers in equity among current equity holders or as any other information on the list of investors provided to the authority as part of the application for certification may change.

b. The authority may at any time request additional information and documentation from a qualifying business regarding the operations, job creation, and economic impact of such qualifying business, and the authority may use such information in preparing and publishing any reports to be provided to the governor and the general assembly to the extent such information is not confidential pursuant to Iowa Code section 15E.29 as enacted by 2025 Iowa Acts, Senate File 657.

261—114.3(15E) Investment and investor requirements.

114.3(1) Only investments made after the date a qualifying business submits an application for certification shall qualify for a tax credit.

114.3(2) A taxpayer shall not claim a tax credit through the program if the taxpayer receives a tax credit for the same investment through another program administered by the authority.

114.3(3) A qualifying business must submit documentation of an investment to the authority, consistent with paragraph 114.4(1)*"b,"* during the first available application window following the investment for the investment to qualify for a tax credit. If the first available application window following the investment concludes prior to approval of certification of the applicable qualifying business, the investor may apply in the first available application window following approval of certification.

114.3(4) Convertible debt shall only be considered an investment in the form of cash to purchase equity as of the date of conversion. Investors that utilize convertible debt must document the date and terms of conversion to equity to be eligible for a tax credit.

114.3(5) Pursuant to the requirements and definitions in Iowa Code chapter 15E, subchapter IV as enacted by 2025 Iowa Acts, Senate File 657, the authority will also verify the following to determine the eligibility of an investment for a tax credit:

a. The amount of the investment is at least $10,000.

b. The investment is not made by an affiliate of the qualifying business or its principals.

c. The investment is not made by an individual or entity that owns 70 percent or more of the qualifying business.

261—114.4(15E) Applying for an investment tax credit.

114.4(1) *Annual business application.* The annual application submitted by qualifying businesses will include:

a. A report from the business of any changes to the information provided in the application for certification pursuant to subrule 114.2(3).

b. The names, addresses, email addresses, phone numbers, shares or equity interests issued, and consideration paid for the shares or equity interests of all shareholders or equity holders, including but not limited to investors who may qualify for the tax credits and the date on which all investments were made.

c. Documentation of the ownership, affiliates, and principals of the qualifying business and of its investors sufficient to allow the authority to determine the following:

(1) Whether any investors are ineligible for a tax credit because the investor is an affiliate of the qualifying business or its principals.

(2) Whether any investors are ineligible for a tax credit because the individual or entity owns 70 percent or more of the qualifying business.

(3) Whether tax credits issued to an investor and the investor's spouse or dependent would exceed the maximum allowed pursuant to Iowa Code section 15E.27(2)*"b"*(1) as enacted by 2025 Iowa Acts, Senate File 657.

d. A signed statement from an officer, director, manager, member, or general partner of the qualifying business certifying the accuracy of the information provided.

e. A listing of investments that are anticipated to be eligible for tax credits during the fiscal year following submission of the application.

f. Any other information the authority may reasonably require to determine the business's continued eligibility for certification as a qualifying business and its investors' eligibility to receive tax credits or to allow the authority to estimate demand for tax credits.

114.4(2) *Application window.* For fiscal years beginning on or after July 1, 2026, the annual application required pursuant to Iowa Code section 15E.28(5) as enacted by 2025 Iowa Acts, Senate File 657, shall be submitted electronically to the authority from September 1 to December 31 each year. For the fiscal year beginning July 1, 2025, the authority will accept applications as soon as practicable after [effective date of this rulemaking] for a period not to exceed 30 days. The authority may adjust the annual application period dates under extenuating circumstances and will provide notice of adjustments on the authority's website. The authority may cease accepting applications during any annual application period if the requested tax credits for the program and the requested tax credits for innovation fund investment tax credits available pursuant to Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657, exceed $12 million. Applications shall be date- and time-stamped by the authority in the order in which such applications are received.

114.4(3) *Board approval of maximum tax credits.* The board will determine the total amount of tax credits available for each fiscal year pursuant to Iowa Code section 15.119 as amended by 2025 Iowa Acts, Senate File 657. The authority will make its initial allocation of tax credits to eligible investors based on the order in which applications are received until the maximum aggregate amount of credits authorized for issuance has been reached for any fiscal year.

114.4(4) *Investor information and deadline.* Additional information that may be requested from investors identified by a qualifying business includes proof of investment and the investor's tax identification number. An eligible investor must provide any information requested by the authority to verify the eligibility of the investor and to allow the authority to issue a tax credit certificate. Such information shall be provided within 30 days of a request from the authority unless a request for extension is approved by the authority in writing.

114.4(5) *Tax credit approval.* Authority staff will verify the continued eligibility of qualifying businesses and the eligibility of investments prior to approval of tax credits by the director. Tax credits will be approved by the director on a first-come, first-served basis until the maximum amount of tax credits approved by the board is fully utilized. Applications that exceed the maximum amount of tax credits approved by the board will be denied.

114.4(6) *Tax credit amount.* The location of the principal business operations will be utilized to determine whether a qualifying business is located in a rural area or an urban area for the purposes of establishing the amount of a tax credit pursuant to Iowa Code section 15E.27(2)*"a"* as enacted by 2025 Iowa Acts, Senate File 657.

114.4(7) *Tax credit limitations.* Tax credits are limited by the following:

a. The total amount of tax credits available for the program, approved by the board pursuant to Iowa Code section 15.119 as amended by 2025 Iowa Acts, Senate File 657.

b. The maximums allowed per fiscal year for a natural person, corporation, or other entity pursuant to Iowa Code section 15E.27(2) as enacted by 2025 Iowa Acts, Senate File 657.

c. The maximum allowed per fiscal year for any one qualifying business pursuant to Iowa Code section 15E.27(2) as enacted by 2025 Iowa Acts, Senate File 657.

114.4(8) *Denial of applications.* Applications received by the authority that exceed the limitations described in Iowa Code sections 15.119 as amended and 15E.27 as enacted by 2025 Iowa Acts, Senate File 657, and in subrule 114.4(7) will be denied, regardless of whether the investment was otherwise eligible to receive a tax credit award. Any application that can be partially approved without exceeding the applicable maximum amounts will be approved as to the portion less than the maximum amounts and denied as to the portion greater than the maximum amounts. For example, if an application is eligible for $50,000 of tax credits, but there is only $30,000 of the business maximum amount available, the application will be approved for $30,000 and denied for $20,000.

261—114.5(15E) Tax credit certificates.

114.5(1) *Issuance by the authority.* The authority shall issue tax credit certificates to investors pursuant to Iowa Code section 15E.28 as enacted by 2025 Iowa Acts, Senate File 657, provided, however, that such tax credit certificate shall be subject to rescission pursuant to paragraph 114.2(5)*"d."*

114.5(2) *Vested right.* A taxpayer does not obtain a vested right in a tax credit until a certificate has been issued by the authority.

114.5(3) *Claiming an investment tax credit.* An investor that has been issued a tax credit certificate by the authority may claim the credit in accordance with any applicable rules adopted by the department of revenue.

These rules are intended to implement Iowa Code chapter 15E, subchapter IV as enacted by 2025 Iowa Acts, Senate File 657.

ARC 9671C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to tax credits for investments in qualifying businesses and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 115, "Tax Credits for Investments in Qualifying Businesses," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 15.106A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2025 Iowa Acts, Senate File 657.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 115. The chapter describes the policies and procedures applicable to tax credits for investments in qualifying businesses,

available pursuant to Iowa Code chapter 15E, subchapter V. The tax credit was repealed by 2025 Iowa Acts, Senate File 657.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025. A public hearing was held on the following date(s):

- September 23, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Authority for a waiver of the discretionary provisions, if any, pursuant to 261—Chapter 199.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on December 4, 2025. Comments should be directed to:

Lisa Connell
Iowa Economic Development Authority
1963 Bell Avenue, Suite 200
Des Moines, Iowa 50315
Phone: 515.348.6163
Email: lisa.connell@iowaeda.com

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 9:15 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
December 4, 2025 2:30 to 2:45 p.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Authority and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **261—Chapter 115**.

ARC 9672C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to tax credits for investments in certified innovation funds and providing an opportunity for public comment

The Economic Development Authority (Authority) hereby proposes to rescind Chapter 116, "Tax Credits for Investments in Certified Innovation Funds," Iowa Administrative Code, and to adopt a new Chapter 116 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 15.106A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 15E.52 and 2025 Iowa Acts, Senate File 657.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 116 and adopt a new chapter in lieu thereof. The proposed chapter describes the policies and procedures applicable to tax credits for investments in certified innovation funds, available pursuant to Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657. The program stimulates venture capital investment in innovative Iowa businesses.

The proposed chapter is clearer and more concise throughout and omits language that duplicates statute. Additionally, the proposed chapter incorporates changes to the program and its available allocation of tax credits in 2025 Iowa Acts, Senate File 657.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025. A public hearing was held on the following date(s):

- September 23, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Authority for a waiver of the discretionary provisions, if any, pursuant to 261—Chapter 199.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on December 4, 2025. Comments should be directed to:

Lisa Connell
Iowa Economic Development Authority
1963 Bell Avenue, Suite 200
Des Moines, Iowa 50315
Phone: 515.348.6163
Email: lisa.connell@iowaeda.com

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 9 to 9:15 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
December 4, 2025 2:30 to 2:45 p.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Authority and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 261—Chapter 116 and adopt the following **new** chapter in lieu thereof:

CHAPTER 116
TAX CREDITS FOR INVESTMENTS IN CERTIFIED INNOVATION FUNDS

261—116.1(15E) Definitions. For purposes of this chapter, unless the context otherwise requires:

"Authority" means the economic development authority created in Iowa Code section 15.105.

"Board" means the same as defined in Iowa Code section 15.102.

"Convertible debt" means debt that may be converted to equity at the option of the debt holder but has not yet been converted.

"Equity" means common or preferred corporate stock or warrants to acquire such stock, membership interests in limited liability companies, partnership interests in partnerships, or near equity. Equity shall be limited to securities or interests acquired only for cash and shall not include securities or interests acquired at any time for services, contributions of property other than cash, or any other non-cash consideration.

"Innovation fund" means the same as defined in Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657.

"Innovative business" means the same as defined in Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657.

"Investor" means a taxpayer that makes an investment in an innovation fund.

"Program" means the tax credit program for investments in certified innovation funds available pursuant to this chapter and Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657.

261—116.2(15E) Certification of innovation funds.

116.2(1) An innovation fund shall submit an application for certification to the authority prior to the issuance of any investment tax credits to investors in such innovation funds. The innovation fund must submit the application within 120 days from the first date on which the equity investments qualifying for the investment tax credit have been made.

116.2(2) Application forms setting forth the information required to certify the eligibility of an innovation fund may be obtained by contacting the authority.

116.2(3) The authority will not issue a tax credit certificate until the board has certified that a fund meets all of the following criteria:

a. The innovation fund has submitted a copy of the innovation fund's certificate of limited partnership, limited partnership agreement, articles of organization or operating agreement certified by the chief executive officer of the innovation fund.

b. The innovation fund has submitted a signed statement from an officer, director, manager, member or general partner of the fund stating that the criteria established in Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657, are met.

(1) For the purposes of determining whether an innovation fund will make investments in promising early-stage companies that have a principal place of business in the state, "having a principal place of business in the state" means (1) that the business has at least 50 percent of all of its employees in the state, (2) that the business pays at least 50 percent of the business's total payroll to employees residing in the state, or (3) that the home office for a substantial amount of executive employees is in the state.

(2) To establish that the criterion in Iowa Code section 15E.52(7)*"d"* is met, the innovation fund shall provide a detailed description of the framework the innovation fund will use to evaluate a business's growth potential and its ability to produce commercially viable products or services within a reasonable period of time. The description shall list and discuss the criteria and the attendant process that the innovation fund will use to evaluate businesses. The authority will consider requests submitted under Iowa Code section 15.118 or 22.7 to treat the evaluation framework as confidential.

(3) To establish that the criterion in Iowa Code section 15E.52(7)*"e"* is met, an innovation fund shall provide a detailed description of the methods by which each business will be evaluated. An innovation fund shall also submit a plan describing the actions it will take in order to collaborate and coordinate with other state and local entities and the ways in which the innovation fund intends to ensure consistency with the policy goals of this chapter. Such a plan shall propose to create relationships that can be substantiated in writing, which may include without limitation contracts, memoranda of understanding, letters of support, affidavits, or joint press releases from or with the entities that will be involved in the collaborative and coordinating efforts or through a list and summary description of the dates and locations for meetings held between the innovation fund and the other entities that allowed for collaboration and coordination between the innovation fund and those entities in an effort to achieve policy consistency.

(4) To establish that the criterion in Iowa Code section 15E.52(7)*"f"* is met, an innovation fund shall provide written confirmation of such relationships, which may include without limitation contracts, memoranda of understanding, letters of support, affidavits, or joint press releases from or with the regents institutions of this state or a list and summary description of the dates and locations for meetings held between the innovation fund and the regents institutions, the names of representatives of regents institutions with whom the innovation fund has met, and a brief summary of the discussions at those meetings.

(5) To establish that the criterion in Iowa Code section 15E.52(7)*"g"* as amended by 2025 Iowa Acts, Senate File 657, is met, an innovation fund shall include provisions in the fund's governing documents that provide for the continued operations of the fund only if the minimum level of investment commitment is reached.

(6) To assist the authority in determining the amount of tax credits to allocate for the program for each fiscal year, an innovation fund shall provide any available information about the timing and amounts of investments anticipated during the existence of the fund.

116.2(4) Upon the authority's receipt of the information and documentation necessary to demonstrate satisfaction of the criteria set forth in Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657, and herein, the authority shall, within a reasonable period of time, determine whether to certify the innovation fund. Incomplete applications will not be forwarded to the board. If the authority determines an innovation fund should not be certified, the authority shall issue written notification to the innovation fund of the denial of certification and provide the reasons why the innovation was not certified. The authority shall issue written notification to the innovation fund that the fund has been certified for the purpose of issuing investment tax credits. This written notification shall contain the following statement:

> The Authority shall not be liable for an innovation fund's failure to maintain compliance with the certification requirements nor for an investor's loss of tax credit certificates resulting from either a failure to maintain compliance or from a revocation.

116.2(5) An innovation fund certified before July 1, 2025, that wishes to take advantage of the changes in 2025 Iowa Acts, Senate File 657, must submit an amended application to the board and demonstrate that the innovation fund meets all new requirements for certification.

261—116.3(15E) Maintenance, reporting, and revocation of certification.

116.3(1) On or before December 31 of each year, each certified innovation fund shall collect and provide to the board, in the manner and form prescribed by the authority, the following information and documentation:

a. The amount of equity investments made in the innovation fund, both on an annual and a cumulative basis.

b. The information required in Iowa Code section 15E.52(10)*"e."*

c. In order to establish that an innovation fund has met the criterion found in Iowa Code section 15E.52(7)*"e,"* documentation and information in the manner and form required by the authority. Such documentation and information may include without limitation contracts, memoranda of understanding, letters of support, affidavits, joint press releases, or a list and summary description of the dates and locations for meetings held between the innovation fund and the other entities that allowed for collaboration and coordination between the innovation fund and those entities in an effort to achieve policy consistency.

d. In order to establish that an innovation fund has met the criterion found in Iowa Code section 15E.52(7)*"f,"* documentation and information in the manner and form required by the authority. Such documentation and information may include without limitation contracts, memoranda of understanding, letters of support, affidavits, joint press releases, or a list and summary description of the dates and locations for meetings held between the innovation fund and regents institutions, the names of representatives of regents institutions with whom the innovation fund has met, and a brief summary of the discussions at those meetings. The innovation fund shall also indicate if any business in which it has invested is commercializing research developed at one of the regents institutions.

e. A list of investors that expected to be eligible for tax credits during the fiscal year in which the report is submitted and the following fiscal year, the date of such investors' investments, and the amount of the investments.

f. To the extent available, documentation sufficient to verify the completion and eligibility of any investment for which a tax credit will be requested during the fiscal year in which the report is submitted.

116.3(2) Upon obtaining the required minimum threshold of $3 million in binding investment commitments, an innovation fund shall submit a statement containing the names, addresses, equity interests issued and consideration paid for the interests of all investors who may initially qualify for the tax credits. An innovation fund shall submit an amended statement as may be necessary from time to time to reflect new equity interests or transfers in equity among current equity holders or as any other information on the list may change. The authority will consider requests submitted under Iowa Code section 15.118 to treat investor names and amounts as confidential.

116.3(3) The board may revoke an innovation fund's certification if any of the following events occur:

a. An innovation fund fails to secure the required $3 million in initial binding investment commitments within one year of the date of certification by the board or fails at any point thereafter to secure investment from its investors of at least $3 million. If an investor in an innovation fund fails to make a capital call by the innovation fund and that failure would cause the innovation fund to fail to secure the required minimum $3 million in investment, then the authority will allow the innovation fund a period of not more than 120 days after receiving notice of the failed capital call to secure additional investment commitments sufficient to meet the required minimum investment.

b. An innovation fund fails to timely submit the report required in Iowa Code section 15E.52(9).

c. An innovation fund fails to maintain the eligibility criteria as set forth in Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657.

The board may forbear revocation under this subrule for good cause shown or for demonstration of extenuating circumstances. Such forbearance shall be at the board's discretion and for the period of time determined by the board to be in the best interest of the program and the state of Iowa.

116.3(4) If the board finds that a fund is out of compliance or revokes an innovation fund's certification, the board will not issue tax credit certificates to investors in the innovation fund until the innovation fund manager demonstrates to the board that the innovation fund again meets the eligibility criteria set forth in Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657. If an investor makes an equity investment prior to a notice of noncompliance and a revocation of an innovation fund's certification, the board will issue the tax credit certificate as set forth in rule 261—116.6(15E). If an investor is issued a tax credit certificate prior to a revocation of certification, the investor shall have all of the rights described in Iowa Code section 15E.52(5) as amended by 2025 Iowa Acts, Senate File 657.

261—116.4(15E) Investment and investor requirements.

116.4(1) Investments made more than 120 days before an innovation fund applies for certification are not eligible for a tax credit.

116.4(2) A taxpayer shall not claim a tax credit through the program if the taxpayer receives a tax credit for the same investment through another program administered by the authority.

116.4(3) For investments made on or after July 1, 2026, an investor must apply for a tax credit during the first available application window following the investment for the investment to qualify for a tax credit. If the first available application window following the investment concludes prior to approval of certification of the applicable innovation fund, the investor may apply in the first available application window following approval of certification.

116.4(4) Convertible debt shall only be considered an investment in the form of cash to purchase equity as of the date of conversion. Investors that utilize convertible debt must document the date and terms of conversion to equity to be eligible for a tax credit.

261—116.5(15E) Application for the investment tax credit certificate.

116.5(1) *Investor application.* Investors may apply for an investment tax credit certificate for each equity investment made in a certified innovation fund by submitting an application to the authority for approval by the board and providing such other information and documentation as may be requested by the authority. A certified innovation fund shall provide any information and documentation requested by the authority relating to an investment, including proof of investment.

116.5(2) *Application window.* For fiscal years beginning on or after July 1, 2026, applications shall be submitted electronically to the authority from September 1 to December 31 each year. The authority may adjust the annual application period dates under extenuating circumstances and will provide notice of adjustments on the authority's website. The authority may cease accepting applications during any annual application period if the requested tax credits for the program and the requested tax credits for the seed investor tax credit program available pursuant to Iowa Code chapter 15E, subchapter IV, as enacted by 2025 Iowa Acts, Senate File 657, exceed $12 million. Applications shall be date- and time-stamped by the authority in the order in which such applications are received.

116.5(3) *Board approval of maximum tax credits.* The board will determine the total amount of tax credits to allocate for each fiscal year pursuant to Iowa Code section 15.119 as amended by 2025 Iowa Acts, Senate File 657.

116.5(4) *Recommendation and approval of tax credits.* Authority staff will make a recommendation to the board for approval of tax credits to eligible investors. The board will approve tax credit certificates on a first-come, first-served basis until the maximum aggregate amount of credits authorized for issuance has been reached for any fiscal year.

261—116.6(15E) Tax credit certificates.

116.6(1) *Preparation of the certificate.* The tax credit certificate shall be in a form approved by the authority and shall contain the taxpayer's name, address, and tax identification number; the amount of credit; the name of the innovation fund; the year in which the investment was made; and any other information that may be required by the department of revenue.

116.6(2) *Vested right.* A taxpayer does not obtain a vested right in a tax credit until a certificate has been issued by the authority.

116.6(3) *Claiming and transferring tax credits.* To claim a tax credit under this chapter, a taxpayer must attach to that taxpayer's tax return a certificate issued pursuant to Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657, and this chapter when the return is filed with the department of revenue. A tax credit may be claimed in the first year that a certificate is issued. Tax credits shall be claimed in accordance with any applicable rules adopted by the department of revenue. A tax credit may be transferred in accordance with Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657, and any applicable rules adopted by the department of revenue.

261—116.7(15E) Additional information. The authority may at any time request additional information and documentation from an innovation fund regarding the operations, job creation and economic impact of the fund, and the authority may use such information in preparing and publishing any reports to be provided to the governor and the general assembly to the extent such information is not confidential pursuant to Iowa Code sections 15.118 and 22.7 or other applicable law.

These rules are intended to implement Iowa Code section 15E.52 as amended by 2025 Iowa Acts, Senate File 657.

ARC 9660C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to the Hawki program and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to amend Chapter 86, "Healthy and Well Kids in Iowa (Hawki) Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 514I.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 514I.

Purpose and Summary

The purpose of this proposed rulemaking is to correct an error that was made in a recent adopted filing.

The Red Tape Review of Chapter 86 was done in 2024 and was Adopted and Filed in **ARC 9468C** (IAB 8/6/25). During the adoption process, language describing the grace period for premium payment was added back to the chapter. The language had been removed from the chapter proposed in the Regulatory Analysis and the Notice as being duplicative of the State Plan for the program.

Since the 2024 Red Tape Review was initiated in early 2024, a change was made to Iowa's State Plan Amendment (SPA) to comply with a federal requirement for continuous eligibility for children under the age of 19 for both Medicaid and Hawki. This change became effective April 1, 2024, and eliminated the need for a grace period for premium payment for both the Medicaid program and Hawki.

This proposed rulemaking strikes the grace period language from the chapter.

There is no substantive impact because the SPA's authority exceeds that of administrative rule. The Hawki program has not changed, and no children's coverage or eligibility has been or will be impacted.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 7.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria Daniels
Department of Health and Human Services
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: victoria.daniels@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind subrule **86.8(4)**.

ITEM 2. Renumber subrules **86.8(5)** and **86.8(6)** as **86.8(4)** and **86.8(5)**.

ARC 9673C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to payments for foster care and providing an opportunity for public comment

The Human Services Department hereby proposes to rescind Chapter 156, "Payments for Foster Care," Iowa Administrative Code, and to adopt a new Chapter 156 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 232.143, 234.35 and 234.38.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 234.39 and 2025 Iowa Acts, House File 1049.

Purpose and Summary

This proposed chapter underwent a review as a part of the Red Tape Review process laid out in Executive Order 10. As a result of this review, restrictive terms were removed, areas that were duplicative were combined or eliminated, and editorial updates were made to reflect current policies and procedures. This proposed chapter establishes policies and procedures for the computation and collection of parental liability by the Department as laid out in Iowa Code section 234.39. In addition, this proposed rulemaking implements, in part, 2025 Iowa Acts, House File 1049. Section 22 of House File 1049 appropriates $308,765 to increase foster care rates by 5 percent.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking increases financial support provided to kinship caregivers to align with the rates received by foster parents. This is an increase from $310 per month currently to approximately $555 per month. This rulemaking also increases the base daily foster care rate.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 7.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria Daniels
Department of Health and Human Services
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: victoria.daniels@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 441—Chapter 156 and adopt the following **new** chapter in lieu thereof:

CHAPTER 156
PAYMENTS FOR FOSTER CARE

441—156.1(234) Definitions.

"Child welfare services" means age-appropriate activities to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Cost of foster care" means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker is $250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds will be placed in the child's escrow account. The cost for supervised apartment living services purchased from a private provider are to be the actual costs paid by the department.

"Earned income" means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

"Escrow account" means an interest-bearing account in a bank or savings and loan association that is maintained by the department in the name of a particular child.

"Family foster care supervision" means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child's permanency plan goals.

"Foster care" means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care includes but is not limited to the provision of food, lodging, training, education, supervision and health care.

"Foster family care" means foster care provided by a foster family licensed by the department according to 441—Chapter 113, approved by the department according to Iowa Code chapter 237, or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child's age and mental and physical capacity.

"Group care maintenance" means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

"Income" means earned and unearned income.

"Inflation factor" means the amount by which the consumer price index for all urban consumers increased during the calendar year ending December 31 that preceded the contractor's fiscal year end.

"Intellectual disabilities professional" means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and has at least one year of experience working with persons with an intellectual disability.

"Kinship caregiver" means, for this chapter only, a person to whom a child is related by blood, marriage, or adoption, or a person who has a significant, committed, positive relationship with the child, who is caring for a child in foster care pursuant to Iowa Code chapter 232.

"Kinship foster care approval" means the authorization granted to the caregiver by the department to provide child foster care through an expedited process according to Iowa Code chapter 237 and allows

the kinship caregiver to receive maximum financial support and to obtain the information and resources necessary to meet the needs of a child under a court-ordered placement with the kinship caregiver.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Parent" means the biological or adoptive parent of the child.

"Parental liability" means a parent's liability for the support of a child during the period of foster care placement. Liability is determined pursuant to 441—Chapter 99.

"Physician" means a licensed medical or osteopathic doctor as defined in Iowa Code section 135.1(4).

"Prevailing rate" means the maximum combined service and maintenance reimbursement rate the department pays to contracted shelter care providers as authorized by the legislature.

"Provider" means the entity that has executed a contract with the department to provide services.

"Service area manager" means the department employee or designee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Special needs child" means a child with needs for emotional care, behavioral care, or physical and personal care that require additional skills, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, the Foster Child Behavioral Assessment form.

"Unearned income" means any income that is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

441—156.2(234) Foster care recovery. The department will recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, which establishes policies and procedures for the computation and collection of parental liability by child support services.

156.2(1) Funds are to be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department serves as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department is responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent is placed in an account from whence it is applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow, these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow are paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) is made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(234) Rate of maintenance payment for foster family care.

156.3(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa will be made to the foster family based on the following schedule:

Age of child	Daily rate
0 through 5	$18.50
6 through 11	$19.24
12 through 15	$21.06
16 or over	$21.34

156.3(2) *Out-of-state rate.* A monthly payment for care in a foster family home licensed or approved in another state will be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.3(3) *Mother and child in foster care.* When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family is based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.3(4) *Kinship foster care.* When the child in foster care is court-ordered to placement with an approved kinship caregiver to provide child foster care, the rate paid to the approved kinship caregiver is based on the daily amount according to the rate schedule in subrule 156.6(1).

a. When a foster family provides care to a sibling group of three or more children, an additional payment of $1 per day per child may be authorized for each nonspecial needs child in the sibling group.

b. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department caseworker may authorize an additional maintenance payment of $1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the department caseworker. Eligible expenses include the actual cost of the most reasonable passenger fare or gas.

c. A supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The department caseworker will complete Form 470-4401, Foster Child Behavioral Assessment, within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph can begin no earlier than the first day of the month following the month in which Form 470-4401, Foster Child Behavioral Assessment is completed and will be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of $4.81 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $9.62 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $14.44 per day.

(2) The department will review the child's need for this difficulty of care maintenance payment using Form 470-4401, Foster Child Behavioral Assessment:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;

3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and

4. Before a court hearing on guardianship subsidy.

d. All maintenance payments, including difficulty of care payments, are to be documented on Form 470-0716, Foster Family Placement Contract.

156.3(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.3(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the department caseworker shall note the monthly amount the foster family agrees to pay in the family's case file. The amount returned cannot be less than $50 per month.

This rule is intended to implement Iowa Code section 234.38 and chapter 237.

441—156.4(234) Kinship caregiver payment.

156.4(1) A kinship caregiver payment is a monthly payment to financially support the care of a child in a kinship caregiver's home. If approved by the department, kinship caregiver payment will be provided for a period of up to four months.

156.4(2) All of the following conditions apply:

a. For each eligible child living in a kinship placement, a caregiver will receive a monthly payment according to the basic rate schedule in subrule 156.6(1) as a result of a court-ordered placement.

b. The payment will begin after 14 days of the child's placement in the kinship caregiver's home. The 14-day requirement is waived if the child enters the kinship caregiver's home immediately following a paid placement for at least 30 days.

c. The payment will continue for up to four months.

d. The kinship caregiver payment will be terminated if the child no longer resides in the home.

e. Kinship caregivers who receive a foster care payment are not eligible to receive a kinship caregiver payment.

This rule is intended to implement Iowa Code section 232.102.

441—156.5(234) Additional payments.

156.5(1) *Clothing allowance.*

a. When, in the judgment of the department caseworker, clothing is needed at the time the child is removed from the child's home and placed in foster care and annually thereafter as needed based on the date the child entered foster care, an allowance may be authorized, not to exceed $500 for the child through the age of 12 and $750 for the child aged 13 and older, to purchase clothing.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the department caseworker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.5(2) *Supervised apartment living.* When a child is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed $630 if the child does not have sufficient resources to cover initial costs.

156.5(3) *Medical care.* When a child in foster care needs medical care or examinations that are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment will be the same as allowed under the Iowa Medicaid program.

156.5(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care that cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment cannot duplicate or supplement payment through the Medicaid program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.5(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed $650. The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.5(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceed $5 may be authorized by the department caseworker in an amount not to exceed $50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees include:

a. Fees required for participation in school or extracurricular activities; and

b. Fees related to enrolling a child in preschool when a mental health professional or an intellectual disabilities professional has recommended school attendance.

156.5(7) *Respite care.* Respite care for a child in family foster care shall be for up to 24 days per calendar year per placement. Except for a certified respite provider, respite shall be provided by a licensed foster family. The payment rate to the respite foster family is the rate authorized under rule 441—156.6(234) to meet the needs of the child. Certified respite providers deliver foster child respite services in the foster family home for at least five hours a day at $20 per day.

156.5(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child, including but not limited to building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child, including but not limited to specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child, including but not limited to recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services will be comparable to prevailing community standards. Payment rates for child care are established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization will be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

This rule is intended to implement Iowa Code section 234.38.

441—156.6(234) Rate of payment for foster group care.

156.6(1) *In-state reimbursement.* Contracted foster group care facilities licensed or approved in the state of Iowa will be paid for group care maintenance and child welfare services in accordance with contracted terms.

a. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

b. No less than annually, the department will redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions plus the inflation factor based on review of the verified Form 470-5421, Combined Cost Report. If the new allocation differs from the current allocation, the department will:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions plus the inflation factor of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates.

156.6(2) *Out-of-state group care payment rate.* When the department determines that appropriate care is not available in Iowa and a licensed or approved contractor outside Iowa is used, the payment rate for contracted foster group care services will be the Iowa rate unless the director grants an exception. The rate cannot exceed the rate paid for clients from that state.

156.6(3) *Out-of-state placement determination.*

a. Placement. When determining whether appropriate care is available within the state, the director will consider each of the following:

(1) Whether the child's treatment needs are exceptional.

(2) Whether appropriate in-state alternatives are available.

(3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service funds or wrap-around funds.

(4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.

(5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. Procedure. The service area manager or chief juvenile court officer will submit the request for director's exception to the department. This request will be made in advance of placing the child and should allow a minimum of two weeks for a response. The request should contain documentation addressing the criteria for director's approval listed in paragraph 156.6(3)*"a."*

156.6(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, an additional maintenance rate will cover the maintenance needs of the young child. No additional amount is allowed for service needs of the child.

a. The rate is set in the provider contract. The young child maintenance rate is limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and cannot exceed the maintenance rate for the mother. Costs for day care cannot be included in the maintenance rate.

b. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and monitor her care of the young child.

c. The provider shall provide services to the mother to assist her to:

(1) Obtain a high school diploma or high school equivalency.

(2) Develop preemployment skills.

(3) Establish paternity for her young child whenever appropriate.

(4) Obtain child support for the young child whenever paternity is established.

d. The provider shall maintain information in the mother's file on:

(1) The involvement of the mother's parents or of other adults.

(2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.

(3) A decision of the minor to keep and raise her young child.

(4) Plan for the minor's completion of high school or a high school equivalency program.

(5) The parenting skills of the minor parent.

(6) Child care and transportation plans for education, training or employment.

(7) Ongoing health care of the mother and child.

(8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

e. The provider designates $35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.

441—156.7(234) Payment for reserve bed days.

156.7(1) *Group care facilities.* The department will provide payment for group care maintenance and child welfare services according to the following requirements.

a. Family visits. Reserve bed payment will be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the department caseworker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility will be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(6) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(7) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case can payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Hospitalization. Reserve bed payment will be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the department caseworker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(6) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case can payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. Runaways. Reserve bed payment will be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the department caseworker within 24 hours after the child runs away.

(2) The intent of the department and the facility will be for the child to return to the facility once the child is found.

(3) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. Preplacement visits. Reserve bed payment will be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility will be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment will be canceled and payment shall be returned if the facility refuses to accept the child back.

(5) Payment will not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.7(2) *Foster family care.*

a. Family visits. Reserve bed payment will be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family will be for the child to return to the foster family home after the visit.

(3) Payment will be canceled and payments shall be returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

b. Hospitalization. Reserve bed payment will be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family will be for the child to return to the foster family home after the hospitalization.

(2) Payment will be canceled and payments shall be returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(4) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. Runaways. Reserve bed payment will be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the department caseworker within 24 hours after the child runs away.

(2) The intent of the department and the foster family will be for the child to return to the foster family home once the child is found.

(3) Payment will be canceled and payments shall be returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment cannot exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment will be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home will be for the child to return to the foster family home.

(3) Payment will be canceled and payment shall be returned if the foster family home refuses to accept the child back.

(4) Payment cannot exceed two consecutive days.

156.7(3) *Shelter care facilities.*

a. Hospitalization. Reserve bed payment will be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the department caseworker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility will be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(6) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment cannot exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment will be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility will be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment will be canceled and payment shall be returned if the facility refuses to accept the child back.

(5) Payment will not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. Family visits. Reserve bed payment will be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the department caseworker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility will be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(6) If the department agrees that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(7) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment cannot exceed seven consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 14 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. Runaways. Reserve bed payment will be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the department caseworker within 24 hours after the child runs away.

(2) The intent of the department and the facility will be for the child to return to the facility once the child is found.

(3) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(4) If the department agrees that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment cannot exceed seven consecutive days, except upon prior written approval of the service area manager. In no case can payment exceed 14 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

441—156.8(234) Emergency juvenile shelter care payment. Contracted juvenile shelter care facilities approved or licensed in Iowa will be paid in accordance with contracted terms, not to exceed the allowable costs as permitted by Iowa Code section 232.141(8).

This rule is intended to implement Iowa Code sections 234.6 and 234.39.

441—156.9(234) Supervised apartment living.

156.9(1) *Child monthly stipend.* For each eligible child living in a supervised apartment living situation, the monthly stipend payment for the child is $787.50. This payment may be paid to the child or another payee, other than a department employee, for the child's living expenses.

156.9(2) *Service.* When services for a youth in supervised apartment living are purchased, the service components and any special provisions shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35.

441—156.10(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

This rule is intended to implement Iowa Code section 234.39.

441—156.11(234) Child's earnings. Earned income of a child who is in foster care shall be reported to the department, and the earned income's use shall be part of the child's plan for service, but the income cannot be used towards the cost of the child's care as established by the department.

This rule is intended to implement Iowa Code section 234.39.

441—156.12(234) Trust funds and investments.

156.12(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker will assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income cannot be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments will be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available, the maintenance payment is terminated.

156.12(2) The department is the payee for income from any trust funds or investments unless limited by the trust.

156.12(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of $1,500 is applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

441—156.13(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home is limited to the amount negotiated pursuant to rule 441—201.5(600) and cannot exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

441—156.14(234) Eligibility for foster care payment.

156.14(1) *Client eligibility.* Foster care payment is limited to the following populations.

a. Youth under the age of 18 are eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement will be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52(2)*"d,"* 232.102(1), or 232.117.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20(1) or 232.21.

3. The department has agreed to provide foster care under a voluntary placement agreement pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care is limited to placements that have been authorized by the department and that conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) are eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.14(1)*"b"*(3), payment for a child who is 18 years of age is limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.14(1)*"b"*(3), payment for a child who is 19 years of age will be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs 156.14(1)*"b"*(1) and *"b"*(2) will be granted for all unaccompanied refugee minors. The child's eligibility for the exception will be documented in the case record. The service area manager or designee will grant an exception for other children when the child meets all of the following criteria.

1. The child does not have an intellectual disability. Funding for services for persons with an intellectual disability is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" means that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds that may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, will be considered encumbered and no longer available. Each service area's funding allocation will be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother is eligible for the extra payment for her young child living with her in care as set forth in subrules 156.3(3) and 156.6(4) and if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.14(2) *Provider eligibility for payment.* Providers of foster care services shall have a foster care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

ARC 9664C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to volunteer health care provider program and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 88, "Volunteer Health Care Provider Program," Iowa Administrative Code, and to adopt a new Chapter 88 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 135.24.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 135.24.

Purpose and Summary

This proposed rulemaking implements Iowa Code section 135.24, which describes the Volunteer Health Care Provider Program (VHCPP). The VHCPP was established to defend and indemnify eligible individual volunteer health care providers and protected clinics providing free health care services. This proposed chapter was scheduled for a 2025 Red Tape Review as instructed in Executive Order 10.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 641—Chapter 88 and adopt the following **new** chapter in lieu thereof:

CHAPTER 88
VOLUNTEER HEALTH CARE PROVIDER PROGRAM

641—88.1(135) Definitions. For the purpose of these rules, the following definitions will apply:

"Charitable organization" means the same as defined in Iowa Code section 135.24.

"Defend" means that the office of the attorney general will provide the individual volunteer health care provider and protected clinic with legal representation at no cost to the individual volunteer health care provider or protected clinic.

"Field dental clinic" means the same as defined in Iowa Code section 135.24.

"Free clinic" means the same as defined in Iowa Code section 135.24.

"Health care facility" means a residential care facility, a nursing facility, or an intermediate care facility for persons with an intellectual disability.

"Health care provider" means the same as defined in Iowa Code section 135.24.

"Health care services" means services received from a health care provider at a protected clinic or sponsor entity, as provided in Iowa Code section 135.24 and these rules, and approved in a protection agreement or sponsor entity agreement. The agreement covers "health care services" that are volunteer, uncompensated services. For those services to qualify as volunteer, uncompensated services under this chapter, the individual volunteer health care provider, health care provider, protected clinic, or sponsor entity will receive no compensation for any services provided under the agreement and shall not bill or accept compensation from the person, or any public or private third-party payor, for the specific services provided.

"Indemnify" means that the state of Iowa will pay all sums that the individual volunteer health care provider or protected clinic holding a protection agreement with the VHCPP is legally obligated to pay as damages because of any claim made against the individual volunteer health care provider or protected clinic that arises out of the provision of free health care services rendered or that should have been rendered by the individual volunteer health care provider or protected clinic.

"Individual volunteer health care provider" means any one of the health care providers defined in Iowa Code section 135.24 who has a fully executed protection agreement with the VHCPP.

"License" means a license, certification or registration issued to a person by a licensing authority that evidences the granting of authority to engage in a profession or occupation.

"Major surgical procedure" means a surgical procedure not ordinarily performed in a private provider's office, free clinic, or specialty health care provider office and includes the surgery performed in a hospital as defined in Iowa Code section 135B.1(3) or an organized outpatient health facility.

"Minor surgical procedure" means a surgical procedure ordinarily performed in a private provider's office, free clinic, or specialty health care provider office.

"Organized outpatient health facility" means a facility defined in Iowa Code section 10A.711.

"Permanent site" means a site at which free health care services will be provided on a continuous basis.

"Protected clinic" means field dental clinic, free clinic, or specialty health care provider office providing free care to the uninsured and underinsured. Each protected clinic has a signed protection agreement that provides for defense and indemnification of the protected clinic. The protection agreement will allow the protected clinic to deliver health care services to uninsured and underinsured persons as an agent of the state.

"Protection agreement" means a signed contract providing for defense and indemnification between an individual volunteer health care provider or protected clinic and the VHCPP. This agreement will allow the individual health care provider or protected clinic to deliver health care services to uninsured and underinsured persons as an agent of the state. The agreement covers "health care services" that are volunteer, uncompensated services. For those services to qualify as volunteer, uncompensated services under this chapter, the individual volunteer health care provider, health care provider, and protected clinic will receive no compensation for any services provided under the agreement and will not bill or accept compensation from the person, or any public or private third-party payor, for the specific services provided by the individual volunteer health care provider covered by the agreement.

"Specialty health care provider office" means the same as defined in Iowa Code section 135.24.

"Sponsor entity" or *"sponsor entity clinic"* means a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, organized

outpatient health facility, or field dental clinic. Each sponsor entity has a fully executed sponsor entity agreement. The sponsor entity agreement will allow an individual volunteer health care provider to deliver health care services to uninsured and underinsured persons as an agent of the state.

"Sponsor entity agreement" means a signed contract between the VHCPP and a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, organized outpatient health facility, or field dental clinic allowing an individual volunteer health care provider to deliver free health care services through the VHCPP at the sponsor entity location.

"Temporary site" means a site at which free health care services will be provided for a short period of time not to exceed three days. "Temporary site" includes but is not limited to temporary health fairs, flu shot clinics, and temporary sites that provide back-to-school physicals.

"Underinsured" means that a person does not have adequate insurance, which is determined on cost-exposure to family income with at least one of three indicators: (1) out-of-pocket medical expenses equal to or greater than 10 percent of income; (2) out-of-pocket medical expenses equal to or greater than 5 percent of income if income is less than 200 percent of the federal poverty level; and (3) health plan deductibles equal to or greater than 5 percent of income.

"Volunteer health care provider program" or *"VHCPP"* means the volunteer health care provider program of the department.

641—88.2(135) Eligibility for the volunteer health care provider program.

88.2(1) *Individual volunteer health care provider eligibility.* To be eligible for protection as an employee of the state under Iowa Code chapter 669 for a claim arising from covered health care services, an individual volunteer health care provider shall satisfy each of the following conditions at the time of the act or omission allegedly resulting in injury:

a. The individual volunteer health care provider must hold an active unrestricted license, registration, or certification to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A. The individual volunteer health care provider shall provide a sworn statement attesting that the license, registration, or certification to practice is free of restrictions. The statement shall describe any disciplinary action that has ever been taken against the individual volunteer health care provider by any professional licensing, registering, or certifying authority or health care facility, including any voluntary surrender of license, registration, or certification or other agreement involving the individual volunteer health care provider's license, registration, or certification to practice or any restrictions on practice, suspension of privileges, or other sanctions. The statement shall also describe any malpractice suits that have been filed against the individual volunteer health care provider. The statement provided by a pharmacist shall also describe any disciplinary action that has ever been taken against any pharmacy in which the pharmacist has ever been owner, partner, or officer.

b. Application. The applicant shall submit the following information on forms provided by the VHCPP:

(1) The individual volunteer health care provider's current licensure identification number and expiration date;

(2) The health care services to be voluntarily provided meet all of the following:

1. The services fall under the individual volunteer health care provider's licensed scope of practice;

2. The services are covered health care services listed in paragraph 88.4(1)*"d"*; and

3. The individual volunteer health care provider applicant is willing to voluntarily provide the health care services to those persons who are uninsured and underinsured for the public health purpose of improved health, prevention of illness/injury, and disease management.

c. Agreement. The individual volunteer health care provider shall have a signed and current protection agreement with the VHCPP that identifies the covered health care services within the respective scope of practice and conditions of defense and indemnification as provided in rules 641—88.4(135) and 641—88.5(135).

(1) The protection agreement is only valid during the time that the individual volunteer health care provider maintains a current unrestricted license and only for voluntary services provided in conjunction with a sponsor entity or protected clinic that has its own valid VHCPP protection agreement in effect at the time of service provision.

(2) The protection agreement with the VHCPP will provide that the individual volunteer health care provider shall:

1. Perform only those health care services identified and approved by the VHCPP;
2. Promptly notify the VHCPP of any changes in licensure status;
3. Maintain proper records of the health care services provided;
4. Make no representations concerning eligibility for the VHCPP or eligibility of services for indemnification by the state except as authorized by the department;
5. Cooperate fully with the state in the defense of any claim or suit relating to participation in the VHCPP, including attending hearings, depositions and trials and assisting in securing and giving evidence, responding to discovery and obtaining the attendance of witnesses;
6. Accept financial responsibility for personal expenses and costs incurred in the defense of any claim or suit related to participation in the VHCPP, including travel, meals, compensation for time and lost practice, and copying costs, and agree that the state will not compensate the individual volunteer health care provider for the individual volunteer health care provider's expenses or time needed for the defense of the claim or suit;
7. Receive no direct monetary compensation of any kind for services provided in the VHCPP; and
8. Comply with the protection agreement with the VHCPP concerning approved health care services.

88.2(2) *Protected clinic eligibility.* To be eligible for protection as a state agency under Iowa Code chapter 669 for a claim arising from the provision of covered health care services at a protected clinic, the protected clinic will satisfy each of the following conditions at the time of the act or omission allegedly resulting in injury:

a. The protected clinic will comply with subrules 88.3(1) through 88.3(5).

b. The protected clinic will, upon request from the department, provide to the department a list of all health care providers who provided health care services at the protected clinic at the time of a claim made against the individual health care provider or protected clinic that arises out of the provision of free health care service rendered or that should have been rendered by the individual volunteer health care provider or protected clinic.

c. The protected clinic will only be covered under the VHCPP for the provision of covered health care services by a health care provider providing health care services at the protected clinic who either:

(1) Holds a current individual volunteer health care provider protection agreement with the VHCPP, or

(2) Holds current professional liability insurance coverage and an active unrestricted license, registration, or certification to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A.

d. The protected clinic will submit a list of the clinic board of directors and contact information for the board of directors, if applicable.

e. If the protected clinic is a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, the protected clinic will provide proof of Section 501(c)(3) status to the VHCPP.

f. A protected clinic may allow health care profession students to volunteer at the protected clinic provided that the following conditions are satisfied:

(1) The college, university, or other health care profession educational institution provides professional liability insurance that covers the students;

(2) The protected clinic or the health care profession institution provides general liability and professional liability insurance that covers the students; and

(3) The students provide only those services or activities as are authorized by the education agreement, and such services and activities are provided under the on-site supervision of a health care provider.

88.2(3) *Sponsor entity or sponsor entity clinic.* As a condition of sponsoring individual volunteer health care providers in the VHCPP, a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, organized outpatient health facility, or field dental clinic shall comply with subrules 88.3(1) through 88.3(5).

641—88.3(135) Sponsor entity and protected clinic.

88.3(1) Licensure. The sponsor entity or protected clinic shall be licensed to the extent directed by law for the facility in question.

88.3(2) If the sponsor entity or protected clinic is a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, the sponsor entity or protected clinic shall provide proof of Section 501(c)(3) status to the VHCPP.

88.3(3) Application. The sponsor entity or protected clinic shall submit the following information on forms provided by the VHCPP:

a. By category, the patient groups to be served;

b. The health care services to be provided;

c. The site where free health care services are to be provided;

d. Classification of each site as a permanent site or temporary site; and

e. The services that will be provided to those persons who are uninsured and underinsured for the public health purpose of improved health, prevention of illness/injury, and disease management.

88.3(4) Agreement. A signed and current sponsor entity agreement or protected clinic agreement will exist with the VHCPP that will:

a. Provide that the individual volunteer health care provider or health care provider within a protected clinic and the individual volunteer health care provider within a sponsor entity will perform only those health care services identified and approved by the VHCPP;

b. Identify by category the patient groups to be served;

c. Identify the sites at which the free health care services will be provided;

d. Identify as a permanent site or temporary site for the provision of free health care services through the VHCPP;

e. Provide that the sponsor entity or protected clinic will maintain proper records of health care services for a period of seven years from the date of service or, in the case of a minor, for a period of one year after the minor has reached the age of majority; and

f. Provide that the sponsor entity agrees that only the individual volunteer health care provider or protected clinic covered under a current VHCPP protection agreement at the time of the service provision in a claim is afforded protection under Iowa Code section 135.24 and that the state assumes no obligation to the sponsor entity, its employees, officers, or agents. The sponsor entity or protected clinic shall submit a statement, that will be submitted on forms provided by the VHCPP, attesting that the sponsor entity or protected clinic and its staff, employees and volunteers agree to:

(1) Cooperate fully with the state in the defense of any claim or suit relating to participation in the VHCPP, including attending hearings, depositions and trials and assisting in securing and giving evidence, responding to discovery and obtaining the attendance of witnesses;

(2) Accept financial responsibility for the sponsor entity's or protected clinic's expenses and costs incurred in the defense of any claim or suit related to participation in the VHCPP, including travel, meals, compensation for time and lost practice, and copying costs, and agree that the state will not compensate the sponsor entity or protected clinic for expenses or time needed for the defense of the claim or suit;

(3) Receive no direct monetary compensation of any kind for health care services provided in the sponsor entity or protected clinic; and

(4) Comply with the sponsor entity agreement or protected clinic agreement with the VHCPP concerning approved health care services.

88.3(5) General liability insurance. The sponsor entity or protected clinic shall submit proof of general liability insurance for the clinic site.

641—88.4(135) Covered health care services. An individual volunteer health care provider holding a current protection agreement with the VHCPP will be afforded the protection of an employee of the state under Iowa Code chapter 669, and a protected clinic holding a current protection agreement with the VHCPP will be afforded protection as an agency of the state under Iowa Code chapter 669, only for claims for injury alleged to have been proximately caused by an individual volunteer health care provider's provision of covered health care services or solely on the basis of the individual volunteer health care provider's participation in the sponsor entity or protected clinic.

88.4(1) Covered health care services are only those that are:

a. Identified in the protection agreement with the VHCPP;

b. In compliance with these rules;

c. Provided by or under the direct supervision of the individual volunteer health care provider;

d. Health care services of:

(1) Advanced registered nurse practitioners for: well-child examinations; annual adult examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; immunizations; and minor surgical procedures. Certified registered nurse anesthetists may provide anesthesia services for major surgical procedures only if the following conditions are satisfied:

1. The surgery is performed in a hospital as defined in Iowa Code section 135B.1(3) or an organized outpatient health facility;

2. The hospital or organized outpatient health facility at which the surgery is performed has executed a sponsor entity agreement;

3. The physician performing the surgery provides or ensures the provision of adequate presurgical and postsurgical care, including any follow-up necessary to address postoperative complications; and

4. The physician performing the surgery is an individual specialty health care provider or part of a group of specialty health care providers that has registered with the department as a specialty health care provider office.

(2) Audiologists for: testing, measurement and evaluation related to hearing and hearing disorders and associated communication disorders for the purpose of nonmedically identifying, preventing, modifying or remediating such disorders and conditions including the determination and use of appropriate amplification; patient instruction/counseling; patient habilitation/rehabilitation; and referrals.

(3) Bachelor social workers for: psychosocial assessment and intervention through direct contact with clients; referral to other qualified resources for assistance; performance of social histories; problem identification; establishment of goals and monitoring of progress; interviewing techniques; counseling; social work administration; supervision; evaluation; interdisciplinary consultation and collaboration.

(4) Chiropractors for: examinations; diagnosis and treatment; health education; and health maintenance.

(5) Dental assistants for: intraoral services; extraoral services; infection control; radiography; and removal of plaque or stain by toothbrush, floss, or rubber cup coronal polish.

(6) Dental hygienists for: assessments and screenings; health education; health maintenance; and preventive services (cleaning, X-rays, sealants, fluoride treatments, fluoride varnish).

(7) Dentists for: dental examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; and minor surgical procedures.

(8) Emergency medical care providers for: airway/ventilation/oxygenation; assisted medications—patient's; cardiovascular/circulation; immobilization; IV initiation/maintenance/fluids; and medication administration—routes.

(9) Independent social workers for: psychosocial assessment, diagnosis, and treatment; performance of psychosocial histories; problem identification; evaluation of symptoms and behavior; assessment of psychosocial and behavioral strengths and weaknesses and effects of the environment on behavior; psychosocial therapy; differential treatment planning; and interdisciplinary consultation.

(10) Licensed practical nurses for: supportive or restorative care.

(11) Marital and family therapists for: marital and family therapy; and application of counseling techniques in the assessment and resolution of emotional conditions.

(12) Master social workers for: psychosocial assessment, diagnosis, and treatment; performance of psychosocial histories; problem identification; evaluation of symptoms and behavior; assessment of psychosocial and behavioral strengths and weaknesses and effects of the environment on behavior; psychosocial therapy; differential treatment planning; and interdisciplinary consultation.

(13) Mental health counselors for: mental health counseling; and counseling services involving assessment, referral and consultation.

(14) Occupational therapists for: evaluation and treatment of problems interfering with functional performance in persons impaired by physical illness or injury, emotional disorder, congenital or developmental disability or the aging process.

(15) Optometrists for: examinations; diagnosis and treatment of the human eye and adnexa; health education; and health maintenance.

(16) Pharmacists for: drug dispensing; patient counseling; health screenings and education; and immunizations.

(17) Physical therapists for: interpretation of performance, tests, and measurements; evaluation and treatment of human capabilities and impairments; use of physical agents, therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment; establishment and modification of physical therapy program; treatment planning; and patient instruction/education.

(18) Physicians and physician assistants for: well-child examinations; annual adult examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; immunizations; and minor surgical procedures. Physicians may perform major surgical procedures only if the following conditions are satisfied:

1. The surgery is performed in a hospital as defined in Iowa Code section 135B.1(3) or an organized outpatient health facility;
2. The hospital or organized outpatient health facility at which the surgery is performed has executed a sponsor entity agreement;
3. The physician provides or ensures the provision of adequate presurgical and postsurgical care, including any follow-up necessary to address postoperative complications; and
4. The physician performing the surgery is an individual specialty health care provider or part of a group of specialty health care providers that has registered with the department as a specialty health care provider office.

(19) Podiatrists for: examinations; diagnosis and treatment; health education; health maintenance; and minor surgical procedures.

(20) Psychologists for: counseling and the use of psychological remedial measures with persons with adjustment or emotional problems.

(21) Registered nurses for: well-child examinations; annual adult examinations; treatment of acute and chronic conditions; health education; health maintenance; and immunizations.

(22) Respiratory therapists for: diagnostic and therapeutic use of administration of medical gases, aerosols, and humidification, not including general anesthesia; pharmacologic agents relating to respiratory care procedures; bronchopulmonary hygiene; specific diagnostic and testing techniques employed in the medical management of patients to assist in diagnosis, monitoring, treatment, and research of cardiopulmonary abnormalities; and pulmonary function testing.

(23) Speech pathologists for: testing, measurement and evaluation related to the development and disorders of speech, fluency, voice or language for the purpose of nonmedically preventing, ameliorating, modifying or remediating such disorders and conditions; patient instruction/counseling; patient habilitation/rehabilitation; and referrals.

88.4(2) Experimental procedures or procedures and treatments that lack sufficient evidence of clinical effectiveness are excluded from the VHCPP.

641—88.5(135) Defense and indemnification. The state will defend and indemnify an individual volunteer health care provider or a protected clinic for a claim arising from the VHCPP only to the extent provided by Iowa Code chapter 669 and section 135.24. Persons or entities other than the participating individual volunteer health care provider or protected clinic are not considered state

employees or state agencies under Iowa Code chapter 669. Defense and indemnification of the individual volunteer health care provider or a protected clinic under Iowa Code chapter 669 and section 135.24 will occur only if all of the following are met:

88.5(1) The claim involves medical injury alleged to have been proximately caused by health care services that were identified and approved in the protection or sponsor agreement with the VHCPP and then only to the extent the health care services were provided by or under the direct supervision of the individual volunteer health care provider, including claims based on negligent delegation of health care, or the individual volunteer health care provider is named as a defendant solely because of the individual volunteer health care provider's participation in the protected clinic or sponsor entity clinic.

88.5(2) The claim arises from covered health care services that were performed at a site identified and approved in the protection agreement with the VHCPP.

88.5(3) The claim arises from covered health care services provided through a protected clinic or sponsor entity clinic identified and approved in the individual volunteer health care provider's protection agreement with the VHCPP and that meets the necessities of rule 641—88.2(135).

88.5(4) The individual volunteer health care provider, health care provider, protected clinic, or sponsor entity clinic that provided the health care services receives no direct monetary compensation of any kind and no promise to pay compensation for the health care services that allegedly resulted in medical injury.

88.5(5) The health care services are provided to a patient who is a member of a patient group identified in the sponsor entity or protected clinic protection agreement with the VHCPP.

88.5(6) The individual volunteer health care provider, protected clinic, or sponsor entity clinic is eligible and registered as provided in rule 641—88.2(135) or the care is provided by a health care provider who holds current professional liability insurance coverage and an active unrestricted license to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A and has been approved by the VHCPP.

641—88.6(135) Term of agreement.

88.6(1) *Individual volunteer health care provider.* The protection agreement with the VHCPP will expire five years from the date of execution. Individual volunteer health care providers may apply for renewal by filing an application at least 30 days prior to expiration of the protection agreement.

88.6(2) *Protected clinic.* The protection agreement with the VHCPP will expire five years from the date of execution. The protected clinic may apply for renewal by filing an application at least 30 days prior to expiration of the protection agreement. It is anticipated that temporary sites may change over the five-year period. An updated list of temporary site location or service provision changes will be provided to the department for review and acceptance at least one week prior to service provision at the temporary site. Location or service provision changes to permanent sites will necessitate a protection agreement amendment.

88.6(3) *Sponsor entity.* The sponsor entity agreement with the VHCPP will expire five years from the date of execution. Sponsor entities may apply for renewal by filing an application at least 30 days prior to expiration of the sponsor entity agreement. It is anticipated that temporary sites may change over the five-year period. An updated list of temporary site location or service provision changes will be provided to the department for review and acceptance at least one week prior to service provision at the temporary site. Location or service provision changes to permanent sites will necessitate a protection agreement amendment.

641—88.7(135) Reporting necessities and duties.

88.7(1) Upon obtaining knowledge or becoming aware of any injury allegedly arising out of the negligent rendering of, or the negligent failure to render, covered health care services under the VHCPP, a participating individual volunteer health care provider, protected clinic, or sponsor entity will provide to the VHCPP, as soon as practicable, written notice containing, to the extent obtainable, the circumstance of the alleged injury, the names and addresses of the injured, and any other relevant information.

88.7(2) Upon obtaining knowledge or becoming aware of an injury as defined in subrule 88.7(1), the participating protected clinic or sponsor entity will promptly take all reasonable steps to prevent further or other injury from arising out of the same or similar incidents, situations or conditions.

88.7(3) A participating individual volunteer health care provider, protected clinic, or sponsor entity will immediately notify the Iowa Department of Justice, Special Litigation Division, Hoover State Office Building, Des Moines, Iowa 50319, of service or receipt of an original notice, petition, suit or claim seeking damages from the individual volunteer health care provider, protected clinic or sponsor entity related to participation in the VHCPP.

641—88.8(135) Revocation of agreement. The VHCPP may deny, suspend, revoke, or condition the agreement of an individual volunteer health care provider, protected clinic or sponsor entity for cause, including but not limited to:

1. Failure to comply with the protection agreement or sponsor entity agreement with the VHCPP.
2. Violation of state law governing the respective scope of practice or other law governing the health care services provided under the VHCPP.
3. Making false, misleading, or fraudulent statements in connection with the VHCPP, including determination of eligibility of the individual volunteer health care provider, protected clinic, or sponsor entity or handling of a claim against the individual volunteer health care provider, protected clinic, sponsor entity or the state.
4. Evidence of substance abuse or intoxication affecting the provision of health care services under the VHCPP.
5. Reasonable grounds to believe that the individual volunteer health care provider or health care provider may have provided incompetent or inadequate care to a patient under the VHCPP or is likely to do so.
6. Reasonable grounds to believe that the individual volunteer health care provider's, protected clinic's, or sponsor entity's participation in the VHCPP may expose the state to undue risk.
7. Failure to immediately notify the VHCPP of any disciplinary action brought against the individual volunteer health care provider by the applicable state licensing board.

641—88.9(135) Procedure for revocation of agreement. A proceeding for revocation of an individual volunteer health care provider's protection agreement or a protected clinic's protection agreement or a sponsor entity's agreement for participation will be conducted as a contested case proceeding pursuant to Iowa Code chapter 17A. Iowa Code section 17A.18 does not preclude emergency summary suspension of a protection agreement or a sponsor entity agreement. The VHCPP will immediately notify the appropriate licensing board and the appropriate protected clinic or sponsor entity of revocation of an individual volunteer health care provider's protection agreement.

641—88.10(135) Effect of suspension or revocation. If the VHCPP suspends or revokes an individual volunteer health care provider's protection agreement, sponsor entity protection agreement, or protected clinic's protection agreement, the action will suspend or revoke future protection but will not negate defense and indemnification coverage for covered acts or omissions that occurred during the effective dates of the protection agreement.

641—88.11(135) Protection denied.

88.11(1) *Protection denied—appeal procedure.* An applicant who has been denied protection by the VHCPP may appeal the decision according to the provisions set forth in 441—Chapter 7.

88.11(2) Reserved.

641—88.12(135) Board notice of disciplinary action. The applicable state licensing board will notify the VHCPP of the initiation of a contested case against a protected individual volunteer health care provider or the imposition of disciplinary action, including providing copies of any contested case decision or settlement agreement with the protected individual volunteer health care provider upon request of the VHCPP.

641—88.13(135) Effect of eligibility protection. A fully executed protection agreement of an individual volunteer health care provider or protected clinic as eligible for participation in the VHCPP by the applicable state licensing board and the department is solely a determination that the state will defend and indemnify the individual volunteer health care provider or the protected clinic to the extent provided by Iowa Code section 135.24 and these rules. The protection is not an approval or indication of ability or competence and will not be represented as such. The protected clinic or sponsor entity through which the individual volunteer health care provider provides free health care services will retain responsibility for determining that health care personnel are competent and capable of adequately performing the health care services to be provided.

641—88.14(135) Reporting by a protected clinic or sponsor entity. A reporting form will be provided by the VHCPP to the participating protected clinic or sponsor entity at the time the protected clinic or sponsor entity agreement is approved by the VHCPP. Within 60 days following each calendar quarter, the protected clinic or sponsor entity will provide a report to the VHCPP. At a minimum, the report will include the number of clinic patients receiving free health care services and patient demographics by age, ethnicity, and insurance status.

These rules are intended to implement Iowa Code section 135.24.

ARC 9665C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to BCBA/BCaBA grants program and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 107, "Board-Certified Behavior Analyst and Board-Certified Assistant Behavior Analyst (BCBA/BCaBA) Grants Program," Iowa Administrative Code, and to adopt a new Chapter 107 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 135.181.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 135.181.

Purpose and Summary

This proposed chapter was reviewed as part of the Red Tape Review process laid out by Executive Order 10. As a result of its review, the Department removed restrictive and duplicative terms. The BCBA/BCaBA Grants Program was established to increase access for Iowans to applied behavior analysis services by providing grants to Iowa resident and nonresident applicants who have been accepted for admission or are attending a university, a community college, or an accredited private institution, within or outside the State of Iowa; are enrolled in a program, offered at a physical location or online, that is accredited and meets coursework requirements to prepare the applicant to be eligible for board certification as a behavior analyst or assistant behavior analyst; and demonstrate financial need.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 641—Chapter 107 and adopt the following **new** chapter in lieu thereof:

CHAPTER 107
BOARD-CERTIFIED BEHAVIOR ANALYST AND BOARD-CERTIFIED ASSISTANT BEHAVIOR ANALYST (BCBA/BCaBA) GRANTS PROGRAM

641—107.1(135) Definitions. For the purposes of these rules, the following definitions will apply:

"Board-certified assistant behavior analyst" or *"BCaBA"* means a person who has a bachelor's degree from an accredited university, has completed approved coursework as defined by the international Behavior Analyst Certification Board, has completed a defined period of supervised practical experience, and has passed the BCaBA examination.

"Board-certified behavior analyst" or *"BCBA"* means a person who has an acceptable graduate degree from an accredited university as defined by the international Behavior Analyst Certification Board, has completed acceptable graduate coursework in behavior analysis, has completed a defined period of supervised practical experience, and has passed the BCBA examination.

"Full-time enrollment" means the applicant is enrolled in a program to be eligible for board certification as a behavior analyst or assistant behavior analyst with the appropriate number of semester credit hours as defined by the educational institution.

"Nonresident" means a person who is not a resident.

"Part-time enrollment" means the applicant is enrolled in a program to be eligible for board certification as a behavior analyst or assistant behavior analyst with the appropriate number of semester credit hours as defined by the educational institution.

"Resident" means a natural person who physically resides in Iowa as the person's principal and primary residence and who establishes evidence of such residency by providing the department with one of the following:

1. A valid Iowa driver's license,
2. A valid Iowa nonoperator's identification card,
3. A valid Iowa voter registration card,
4. A current Iowa vehicle registration certificate,
5. A utility bill,
6. A statement from a financial institution,
7. A residential lease agreement,
8. A check or pay stub from an employer,
9. A child's school or child care enrollment documents,
10. Valid documentation establishing a filing for homestead or military tax exemption on property located in Iowa, or
11. Other valid documentation as deemed acceptable by the department to establish residency.

641—107.2(135) Eligibility criteria. To be eligible for a grant, the applicant shall:

107.2(1) Be an Iowa resident or nonresident.

107.2(2) Be accepted for admission to or be attending a university, a community college, or an accredited private institution, within or outside the state of Iowa; be enrolled in a program, offered at a physical location or online, that is accredited and meets coursework requirements to prepare the applicant to be eligible for board certification as a behavior analyst or assistant behavior analyst; and demonstrate financial need.

107.2(3) Have on file with the college student aid commission a current Free Application for Federal Student Aid (FAFSA) and Iowa Financial Aid Application or similar financial aid documentation from another state and submit documentation of financial need as described in the department's request for proposal process.

107.2(4) Agree to practice in the state of Iowa for a period of time, not to exceed four years, as specified in the contract entered into between the applicant and the department at the time the grant is awarded.

107.2(5) Agree, as specified in the contract between the applicant and the department at the time the grant is awarded, that during the contract period, the applicant will assist in supervising an individual working toward board certification as a behavior analyst or assistant behavior analyst or to consult with schools and service providers that provide services and supports to individuals with autism.

641—107.3(135) Priority in grant awards. Priority in the awarding of a grant will be given to resident applicants.

641—107.4(135) Amount of a grant. The department will award funds based upon the amount set aside in the special fund as identified in Iowa Code section 135.181. Moneys appropriated to, and all other moneys specified for deposit in, the fund will be dedicated to the BCBA/BCaBA grants program as established in Iowa Code section 135.181. These rules will be implemented only to the extent that funding is available. The amount of funding awarded to each applicant will be based on the applicant's enrollment status (full-time enrollment or part-time enrollment), the number of applicants, and the total amount of available funds. The total amount of funds awarded to an individual applicant will not exceed 50 percent of the total costs attributable to program tuition and fees, annually. Awarded grant funds will be payable to the student and prorated on the number of semesters or other terms of study to complete the program.

641—107.5(135) Use of funds. Funds awarded may be used to offset the costs attributable to tuition and fees for the accredited behavior analyst or assistant behavior analyst program.

641—107.6(135) Review process.

107.6(1) An applicant shall complete and submit an application to the program in the manner specified by the department. An applicant, if awarded a grant, shall enter into a contract with the department. The department will follow the requirements for competitive bid appeals contained in Division II of 441—Chapter 7.

107.6(2) The department will establish an application process for applicants eligible to receive funding. The application review process and review criteria for preference in awarding the grants will be described in a request for proposals.

107.6(3) An applicant may appeal the denial of a properly submitted grant application. Appeals will be governed by the provisions set forth in Division II of 441—Chapter 7.

These rules are intended to implement Iowa Code section 135.181.

ARC 9667C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to county medical examiners and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 127, "County Medical Examiners," Iowa Administrative Code, and to adopt a new Chapter 127 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 331 and 691.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 331 and 691.

Purpose and Summary

This proposed chapter was reviewed as a part of the Red Tape Review process laid out in Executive Order 10. As a result of this review, restrictive terms were removed, areas that were duplicative were combined or eliminated, and editorial updates were made to reflect current policies and procedures. The proposed chapter outlines the duties and jurisdiction of a County Medical Examiner and the authority provided to a County Medical Examiner to perform investigations and autopsies "over deaths which affect the public interest."

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 641—Chapter 127 and adopt the following **new** chapter in lieu thereof:

CHAPTER 127
COUNTY MEDICAL EXAMINERS

641—127.1(144,331,691) Definitions.

"Autopsy" means the external and internal postmortem examination of a deceased person.

"Cause of death" means the disease or injury that sets in motion the chain of events that eventually results in the death of a person. The physician shall consider "but for" this injury or disease the person would still be living.

"County medical examiner" or *"CME"* means a medical or osteopathic physician or surgeon licensed in the state of Iowa and appointed by the board of supervisors to serve in this capacity.

"County medical examiner investigator" or *"CME-I"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to serve under the supervision of a county medical examiner to assist in death investigations.

"County of appointment" means the county that requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

"Cremation" means the technical process, using heat and flame, that reduces human remains to bone fragments.

"Cremation permit" means an electronic cremation permit approved by the medical examiner.

"Day" means calendar day.

"Death" means the condition as described in Iowa Code section 702.8.

"Death affecting the public interest" means any death of a human being in which the circumstances are sudden, unexpected, violent, suspicious, or unattended, including but not limited to those deaths listed in Iowa Code sections 331.802(3) and 144.29.

"Deputy county medical examiner" or *"DCME"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to assist the county medical examiner in the performance of the county medical examiner's duties.

"EMER" means the electronic medical examiner report.

"External examination" means a close inspection of the exterior of a deceased human body for the purpose of locating, describing, and delineating any and all injuries or other abnormalities. External examination of a body does not constitute an autopsy, even if toxicology samples are obtained.

"Fee" means an amount to be paid to a county medical examiner's office as determined by the board of supervisors of the county of appointment for completion of an investigation, autopsy, or report(s). Fees for services provided by the state medical examiner's office are established in rule 641—126.3(691).

"Manner of death" means the circumstances under which the cause of death occurred and may be specified as follows: natural, accident, suicide, homicide, undetermined, or pending.

"Medical care provider" means an individual licensed or certified in any medical profession, including but not limited to a physician, physician assistant, nurse, emergency medical care provider, certified nurse's aide, pharmacist, physical therapist, and medical technologist.

"Medical examiner" means the state medical examiner, deputy state medical examiner, county medical examiner, or deputy county medical examiner.

641—127.2(331,691) Duties of medical examiners—jurisdiction over deaths that affect the public interest.

127.2(1) *Jurisdiction.* Upon receiving notification of a death that affects the public interest, a medical examiner shall notify any appropriate law enforcement agency not otherwise notified and take charge of the body of the decedent. The body shall not be disturbed or removed from the position in which it was found without authorization from the medical examiner except for the purpose of preserving the body from loss or destruction or permitting the passage of traffic on a highway, railroad, or airport, or unless the failure to remove the body might endanger life, safety, or health.

127.2(2) *Investigation.* A county medical examiner shall conduct a preliminary investigation of the cause and manner of death and utilize the investigative protocol outlined in the County Medical Examiner's Handbook as amended to August 1, 2025, available from the state medical examiner's office. A medical examiner may perform or authorize performance of any scientific study to assist in identifying the cause, circumstances, and manner of death. A medical examiner shall cooperate with other investigating officials and agencies involved and share reports, information, and conclusions with these officials and agencies.

127.2(3) *Reports required.*

a. EMER.

(1) Preparation and filing. A county medical examiner shall electronically enter the examiner's findings in the Preliminary Medical Examiner Report in the EMER system. A county medical examiner must complete and submit the EMER within 14 days of the date of death and file a copy of the EMER with the county attorney within 14 days of the date of the death and retain a copy for the county medical examiner's records.

(2) Content. The EMER shall be completed as fully as possible in light of all available information and may be signed by either a county medical examiner or a county medical examiner investigator acting under the supervision of a county medical examiner. If the cause or manner of death, identity of the decedent, or other information is unknown or pending at the time of filing, "unknown" or "pending" may be written in the appropriate area of the form. If additional information becomes available, this information shall be forwarded to the state medical examiner in written form at such time as it becomes available to be added as a supplement to the file.

b. Jurisdiction declined or terminated. An EMER with designated, abbreviated, or minimal information shall be completed and submitted in accordance with subparagraphs 127.2(3)*"a"*(1) and *"a"*(2) in cases reported to the county medical examiner where jurisdiction is terminated or declined.

127.2(4) *Disposition of body.* After an investigation, including an autopsy if one was performed, the body of the decedent shall be made available to the funeral home designated by a relative or friend of the decedent for burial or appropriate disposition. A medical examiner cannot use influence in favor of a particular funeral director or funeral home. If no one claims a body, it shall be disposed of as provided in Iowa Code chapter 142.

127.2(5) *Coverage.*

a. When an individual is required to report a death to a medical examiner and the county medical examiner cannot be located or is not available, the individual must contact a county medical examiner from any adjacent Iowa county to perform those duties outlined in this chapter. The responding medical examiner has full authority to conduct any procedures necessary to the investigation of the cause and manner of death. If an adjacent county medical examiner is not available, the state medical examiner shall be contacted and may act in the capacity of a county medical examiner.

b. The responding county medical examiner will be reimbursed by the county for which the service is provided for all fees and expenses at the rate that is customarily paid by the county for which the service is provided or at a rate agreed upon by the medical examiner and the board of supervisors of the county for which the service is provided.

641—127.3(331,691) Autopsies.

127.3(1) *Autopsy required.* A county medical examiner shall order that an autopsy be performed in the following cases:

a. All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

b. All cases in which the manner of death is undetermined.

c. All cases involving unidentified bodies.

d. All deaths of children under the age of two when there is not a clear cause of death, including suspected cases of unexpected or unexplained death.

e. All work- and farm-related deaths unless there is an obvious natural cause of death.

f. All drowning deaths.

g. All deaths of commercial vehicle drivers that occur during the performance of their job duties.

h. Deaths due to poisoning.

i. Deaths of airplane pilots who die as a result of an airplane crash. The National Transportation Safety Board and the Federal Aviation Administration should be contacted prior to the autopsy to request specimen kit(s).

j. Deaths due to a natural disaster, including tornadoes and floods.

k. Deaths in a prison, jail or correctional institution or under police custody, where there is not a natural disease process that accounts for the death.

127.3(2) *Autopsy recommended.* It is recommended that a county medical examiner should perform an autopsy or order that an autopsy be performed in the following cases:

a. Deaths of adolescents less than 18 years of age when there is not a natural cause of death.

b. All cases that involve a motor vehicle crash.

c. Deaths from suicide.

d. All pedestrian, bicycle, motorcycle, snowmobile, boating, watercraft, three- or four-wheeler or all-terrain vehicle fatalities.

e. Deaths due to failure of a consumer product.

f. Deaths due to a possible public health hazard.

g. Deaths due to drug or alcohol abuse or overdose.

h. Electrical- and lightning-related deaths.

i. Deaths from burns or smoke or soot inhalation.

j. All deaths related to exposure, such as hypothermia and hyperthermia.

k. All sport-related deaths, including but not limited to deaths from auto racing and deaths resulting from injuries sustained in football, basketball, baseball, softball, soccer, or other games or sports.

127.3(3) *Other deaths.* For those deaths not listed in subrule 127.3(1) or 127.3(2), a county medical examiner will determine whether the public interest requires an autopsy and order that an autopsy be performed. A county medical examiner may consult with the state medical examiner to assist in determining the need for an autopsy.

127.3(4) *Performance of autopsy.*

a. Who may authorize. Autopsies may be authorized by the state medical examiner, the county medical examiner for the county in which the death occurred or the county where any injury contributing to or causing the death was sustained, or the county attorney who would have jurisdiction in any criminal proceeding related to the death.

b. Who may perform. An autopsy must be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with these qualifications. The following types of deaths shall be transported to the office of the state medical examiner for autopsy unless otherwise approved by the state medical examiner:

(1) Deaths of adolescents through 18 years of age when there is not a known or preexisting natural cause of death.

(2) All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

(3) Deaths of children under the age of two years if death results from an unknown cause or is unexpected.

(4) All suspicious suicides.

(5) All high-profile deaths, including but not limited to deaths of elected officials in municipal, state or federal government.

(6) All deaths of inmates occurring in any institutions under the department of corrections as outlined in Iowa Code section 904.102, excluding those deaths that result from a pre-existing medical condition.

c. Permit required—EMER. A medical examiner must complete the EMER. All reasonable efforts must be made to complete the EMER prior to the performance of an autopsy.

127.3(5) *Autopsy report.* A complete record of the findings of the autopsy shall be submitted to the state medical examiner's office, the county attorney of the county where the death occurred and the county attorney of the county where the injury contributing to or causing the death was sustained within 90 days following the date of death unless unusual circumstances requiring further investigation or testing exist. The report filed shall include transcriptions of the autopsy observations and opinions and toxicology reports.

127.3(6) *Out-of-state autopsy.* The body of a decedent may be sent out of state for an autopsy or postmortem examination only if the county medical examiner certifies in writing that the out-of-state autopsy or examination is necessary for any of the following reasons:

a. A forensic pathologist practicing in the state of Iowa is unavailable;

b. Requiring an in-state autopsy would cause financial hardship; or

c. Requiring an in-state autopsy would delay the funeral or burial more than three days.

127.3(7) *Retention and disposal of tissues, organs, and bodily fluids.* The office of the state medical examiner will retain tissues, organs, and bodily fluids as necessary to determine the cause and manner of death or as deemed advisable by the state medical examiner for medical or public health investigation, teaching, or research. Tissues, organs, and bodily fluids will be retained at a minimum for the time periods established by the National Association of Medical Examiners and may be retained for a longer time period at the discretion of the state medical examiner. Tissues, organs, and bodily fluids retained under this subrule will be disposed of without the specific consent or notification of the legal next of kin and in accordance with applicable federal and state regulations, including but not limited to OSHA-recommended biohazard and blood-borne pathogen standards. The anatomical material must be removed from the laboratory premises through use of a contracted, licensed, and bonded medical waste removal service to a medical waste processing center for final disposition.

641—127.4(331,691) Fees.

127.4(1) *Payment of fee and expenses.*

a. A medical examiner receives from the county of appointment or the county of the decedent's residence a fee for each preliminary investigation and report submitted in a case in which a death affects the public interest. A county medical examiner shall also receive from the county of appointment or the county of the decedent's residence the examiner's actual expenses. The fee and expenses are submitted by the county medical examiner to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the county medical examiner. If the county medical examiner does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.

b. A pathologist or other physician who performs an autopsy under medical examiner authorization shall be paid for the services by the county of appointment.

c. Invoices produced for services performed by a county medical examiner, deputy county medical examiner or county medical examiner investigator must be submitted as a joint invoice to the county of appointment when services were rendered in a case by multiple county medical examiner staff.

127.4(2) *Reimbursement.*

a. County of residence different from county of appointment—Iowa resident. The county of the decedent's residence shall reimburse the county of appointment for the fee and expenses paid by the county of appointment.

b. Death caused by criminal defendant. If the person's death is caused by a criminal defendant who has been convicted and sentenced for murder, voluntary manslaughter, involuntary manslaughter, or homicide by vehicle, the county of the person's residence may recover from the defendant the fee and expenses.

c. Out-of-state resident—law enforcement involvement. The fee and expenses of a county medical examiner who performs an investigation or autopsy of a person who dies after being brought into the state for emergency medical treatment by or at the direction of an out-of-state law enforcement officer or public authority will be paid by the state. A claim for payment shall be filed with the state appeal board.

d. Out-of-state resident—no law enforcement involvement. The fee and expenses of a county medical examiner who performs an investigation or autopsy of an out-of-state resident shall be paid by the county of appointment.

641—127.5(144,331,691) Death certificates—deaths affecting the public interest.

127.5(1) *Completion.* The funeral director to whom the body is released shall complete the personal data on the death certificate. The medical examiner must complete the manner of death and cause of death sections of the death certificate within 72 hours after determination of the cause and manner of death. If an autopsy is performed by the state medical examiner, the death certificate medical certifier sections will be completed by the state medical examiner's office.

127.5(2) *Filing.* The funeral director shall file the certificate with the county registrar in the county in which the death occurred. A death certificate shall be filed prior to the issuance of a burial transit permit and prior to disposal of the body.

127.5(3) *Extension of time.* If a medical examiner is unable to complete the manner of death and cause of death sections of the death certificate within the 24-hour time period, the funeral director must file a death certificate form completed with all available information. Such certificate is authority for the issuance of a burial transit permit. Within 15 days, a supplemental report shall be filed with the local registrar that provides the information missing from the original certificate.

641—127.6(331,691) Cremation.

127.6(1) *Permit obtained prior to cremation—cremation permit.* A permit for cremation must be obtained from a county medical examiner or state medical examiner prior to cremation of a body of a decedent. Cremation permits must be completed in the electronic death registry system. For the purposes of this requirement, a hard copy or facsimile of a hard copy shall only be utilized if the electronic death registry system is off-line for four or more hours.

127.6(2) *Requirements for issuance of permit.* A county medical examiner shall direct an inquiry into the cause and manner of death and determine whether the death is one that affects the public interest prior to issuing a cremation permit.

a. Death that affects the public interest. If the death occurred in a manner specified in Iowa Code section 331.802(3) or if reasonable suspicion that the death occurred in such a manner exists, a medical examiner shall view the body, make a personal inquiry into the cause and manner of death, and complete or cause to be completed all necessary autopsy or postmortem examinations prior to issuing a cremation permit.

b. Death that does not affect the public interest. If, following an inquiry into the cause and manner of death, the county medical examiner determines that the death did not occur in a manner specified in Iowa Code section 331.802(3), a medical examiner is not required to view the body prior to issuing a cremation permit. A county medical examiner must certify on the Cremation Permit in the electronic death registry system that the medical examiner's inquiry into the cause and manner of death did not disclose evidence that the death occurred in a manner specified in Iowa Code section 331.802(3).

127.6(3) *Fee.* A fee for the Cremation Permit by Medical Examiner shall be paid by the family, next of kin, guardian of the decedent, or other person authorized to act on behalf of the decedent.

641—127.7(331,691) County medical examiner investigators.

127.7(1) *Appointment.* A county medical examiner may appoint one or more county medical examiner investigators upon approval by the board of supervisors and the state medical examiner.

127.7(2) *Qualifications.*

a. Prior to appointment, a CME-I should possess a minimum of two years of experience as a licensed or certified nurse or medical care provider. A certified peace officer may be appointed to the position of CME-I if a nurse or medical care provider is not available.

b. A CME-I shall satisfy the following criteria:

(1) Prior to or within two years of appointment, attend the St. Louis University School of Medicine Basic Medicolegal Death Investigation Course or its state medical examiner-approved equivalent; and

(2) Prior to or within five years of appointment, obtain certification at the registry level as a death investigator by the American Board of Medicolegal Death Investigators.

c. A CME-I is not required to meet the requirements of paragraph 127.7(2)*"a"* or *"b"* if the individual has functioned in the capacity of a CME-I for a period of five years.

d. If a CME is unable to appoint a CME-I who possesses the qualifications required by paragraph 127.7(2)*"a," "b,"* or *"c,"* the CME may request a waiver. Waiver requests must be submitted in writing to the state medical examiner and include the efforts undertaken by the CME to locate a CME-I who meets the above qualifications; the qualifications of the individual willing to serve in the capacity of a CME-I; and the period of time for which the waiver is requested, not to exceed two years. The state medical examiner has sole discretion to waive the requirements of this rule and may withdraw or modify a waiver request upon a finding that the CME-I has failed to adequately perform the duties of the position or for other good cause.

e. If a CME-I is unable to meet the eligibility requirements for obtaining registry certification due to the small number of cases requiring investigation in the county of appointment, then a waiver must be obtained from the state medical examiner in order for the investigator to continue the investigator's duties. The county medical examiner must submit a request for a waiver in writing with documentation of the number of deaths occurring in the county of appointment that require death investigation. The waiver must be renewed every five years if the required number of investigations has still not been achieved.

127.7(3) *Duties.* A CME-I shall assist in death investigations. A CME-I acting under the supervision of a county medical examiner may sign the EMER. A CME-I cannot sign a certificate of death or a cremation permit.

127.7(4) *Supervision.* A CME-I shall serve under the supervision of a county medical examiner. A CME-I provides services under the direction of a county medical examiner or state medical examiner's office. A CME-I can perform services in a manner that is consistent with the protocol outlined in this chapter.

127.7(5) *Fees.* Fees for the services provided by a CME-I shall be paid by the county of appointment or by the county of the decedent's residence. A CME-I shall receive from the county of appointment or the county of the decedent's residence reimbursement for actual expenses. The fee and expenses must be submitted by the CME-I to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the CME-I. If the CME-I does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.

641—127.8(331,691) Deputy county medical examiners.

127.8(1) *Appointment.* A county medical examiner may appoint one or more DCMEs upon approval by the board of supervisors and the state medical examiner.

127.8(2) *Qualifications.* A DCME must be licensed in the state of Iowa as a medical or osteopathic physician or surgeon.

127.8(3) *Duties.* A DCME serves at the direction of the county medical examiner and may perform any duty of a county medical examiner that is delegated by the county medical examiner to the DCME.

127.8(4) *Fees.* Fees for the services provided by a DCME are paid by the county of appointment or by the county of the decedent's residence. A DCME receives from the county of appointment or the county of the decedent's residence reimbursement for actual expenses. The fee and expenses will be submitted by the DCME to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the DCME. If the DCME does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment pays the invoice.

641—127.9(331,691) Failure to comply with rules. If a county medical examiner, deputy county medical examiner, county medical examiner investigator, pathologist, or other physician fails to comply with these rules, the state medical examiner may provide written notice of the failure to comply to that individual, the appropriate county medical examiner, and the appropriate county board of supervisors. Within 30 days of the date of the notice, the individual to whom the notice was provided shall submit a written response to the state medical examiner, outlining a proposed corrective action plan. If no response is received within the 30 days or if the proposed corrective action plan is unacceptable, the state medical examiner will forward copies of the notice and all pertinent correspondence and information to the board of supervisors for the county that appointed the individual, notifying the board of the individual's failure to comply with these rules.

641—127.10(331,691,22) Confidentiality. Records and reports of a medical examiner may be confidential records pursuant to Iowa Code section 22.7(2), 22.7(5), and 22.7(41) and other provisions of Iowa law. Prior to releasing a medical examiner record or report to a member of the public, a county medical examiner may inform the appropriate law enforcement agency, the county attorney, and the state medical examiner to determine whether release is authorized under Iowa law.

641—127.11(331,691,670) Indemnification. A board of supervisors shall defend, hold harmless, and indemnify a county medical examiner and any properly appointed staff members to the extent provided in Iowa Code chapter 670.

These rules are intended to implement Iowa Code chapters 331 and 691.

ARC 9659C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to emergency medical services and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to amend Chapter 132, "Emergency Medical Services—Service Program Authorization," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 147A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 147A and section 169.4 as amended by 2025 Iowa Acts, Senate File 296.

Purpose and Summary

This proposed rulemaking implements Iowa Code sections 147A.8 and 169.4 as amended by 2025 Iowa Acts, Senate File 296, which provides that emergency medical care providers may diagnose or treat a severely injured police service dog.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025. A public hearing was held on the following date(s):

- October 7, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Adopt the following **new** paragraph **132.3(4)"e"**:

e. Service programs electing to diagnose or treat police service dogs. A service program that elects to have rostered emergency medical care providers diagnose or treat severely injured police service dogs shall develop, maintain, and follow policies and procedures for diagnosing or treating police service dogs. The policies and procedures shall be developed in consultation with a veterinarian holding an active license to practice veterinary medicine in Iowa pursuant to Iowa Code chapter 169.

ARC 9669C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to the love our kids grant program and providing an opportunity for public comment

The Department of Health and Human Services (Department) hereby proposes to rescind Chapter 141, "Love Our Kids Grant," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 321 and Executive Order 10.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 147A.4 and 321.34.

Purpose and Summary

This proposed rulemaking was undertaken as a result of a Red Tape Review pursuant to Executive Order 10. The purpose of the Love our Kids Grant is to provide funding to statewide, regional and local agencies and service programs that serve to promote the development, promotion, and implementation of injury prevention and education for children in Iowa. Funds are provided by the Iowa Department of Transportation, and the Department disburses to eligible agencies across the State. The Iowa Code does not dictate that the funds must be administered via grants. In addition, there is no rulemaking authority for this chapter. Therefore, the Department is proposing to rescind this chapter and distribute funds to agencies through the procurement and contracting process instead of through grants.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **641—Chapter 141**.

ARC 9666C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to Iowa physician orders for scope of treatment and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 145, "Iowa Physician Orders for Scope of Treatment," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Executive Order 10.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 144A.7 and 144D.2.

Purpose and Summary

The Physician Orders for Scope of Treatment (POST) Form is a document that contains medical orders that may be relied upon across medical settings and that consolidates a patient's preferences for life-sustaining treatments and interventions. The purpose of this chapter was to establish the process for the development, review, modification, and posting of the POST Form.

Upon a Red Tape Review of this chapter, it was determined that the language is duplicative of Iowa Code chapter 144D. In addition, there is no rulemaking authority for this chapter. As such, the Department is proposing to rescind the chapter. This will not cause any disruption in the effectiveness of the POST Form as determined by a patient and the patient's medical provider.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

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Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **641—Chapter 145**.

ARC 9663C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to tobacco use prevention and control funding process and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 152, "Tobacco Use Prevention and Control Funding Process," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 142A.6.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 142A.6 and 2024 Iowa Acts, House File 2673.

Purpose and Summary

This proposed rulemaking is being undertaken as a result of Executive Order 10. In addition, this chapter became obsolete effective July 1, 2025, due to the enactment of 2024 Iowa Acts, House File 2673. That legislation, in part, realigned the State's behavioral health service system and repealed Iowa Code chapter 142A, which established the Tobacco Use Prevention and Control Commission. The Commission was dissolved effective July 1, 2025. Because the Commission was dissolved, this chapter is no longer needed and is proposed to be rescinded.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Public Hearing

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Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **641—Chapter 152**.

ARC 9668C

PUBLIC HEALTH DEPARTMENT[641]

Notice of Intended Action

Proposing rulemaking related to child support noncompliance and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 192, "Child Support Noncompliance," Iowa Administrative Code, and to adopt a new Chapter 192 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 252J.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 252J.

Purpose and Summary

This proposed chapter underwent a review as a part of the Red Tape Review process laid out in Executive Order 10. As a result of this review, restrictive terms were removed, areas that were duplicative were combined or eliminated, and editorial updates were made to processes and procedures to ensure they reflect current policies and procedures. This proposed rulemaking requires Department staff to share a notice of child support noncompliance with licensing authorities across the State. Licensing authorities can deny the issuance or renewal of a license upon receipt of a certificate of noncompliance from Child Support Services in accordance with the procedures detailed in Iowa Code chapter 252J.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
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Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 641—Chapter 192 and adopt the following **new** chapter in lieu thereof:

CHAPTER 192
CHILD SUPPORT NONCOMPLIANCE

641—192.1(252J) Definitions. For the purpose of this chapter, the following definitions apply:

"Applicant" means an individual who is seeking the issuance of a license.

"Certificate of noncompliance" means a document as defined in Iowa Code section 252J.1 that is provided by child support services certifying that the applicant or licensee has defaulted on an obligation owed to or collected by child support services.

"License" means the same as defined in Iowa Code section 252J.1.

"Licensing authority" means a board, commission, or any other entity of the department that has authority within this state to suspend or revoke a license or deny the renewal or issuance of a license authorizing a person to engage in a business, occupation, or profession.

641—192.2(252J) Denial of issuance or renewal of a license or suspension or revocation of a license. The licensing authority will deny the issuance or renewal of a license or suspend or revoke a license upon the receipt of a certificate of noncompliance from child support services according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code section 252J.3(7), the following apply:

192.2(1) The notice required by Iowa Code section 252J.8 will be served upon the applicant or licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa

Rule of Civil Procedure 1.305. Alternatively, the applicant or licensee may accept service personally or through authorized counsel.

192.2(2) The suspension, revocation, or denial will be effective no sooner than 30 days following provision of notice to the individual.

192.2(3) Applicants and licensees shall keep the licensing authority informed of all court actions, and all child support services actions taken under or in connection with Iowa Code chapter 252J, and shall provide the licensing authority copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by child support services.

192.2(4) All licensing authority fees required for application, license renewal, or license reinstatement must be paid by applicants or licensees before a license will be issued, renewed, or reinstated after the licensing authority has denied the issuance or renewal of a license pursuant to Iowa Code chapter 252J.

192.2(5) In the event an applicant or licensee timely files a district court action following service of a licensing authority notice pursuant to Iowa Code sections 252J.8 and 252J.9, the licensing authority will continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the licensing authority to proceed. For purposes of determining the effective date of the denial of the issuance, renewal, suspension or revocation of a license, the licensing authority will count the number of days before the action was filed and the number of days after the action was disposed of by the court.

192.2(6) The licensing authority will notify the applicant or licensee in writing through regular first-class mail, or such other means as the licensing authority determines appropriate in the circumstances, within ten days of the effective date of the denial of the issuance or renewal of a license and will similarly notify the applicant or licensee if the license is issued or renewed following the licensing authority's receipt of a withdrawal of the certificate of noncompliance.

641—192.3(17A,22,252J) Sharing of information. Notwithstanding any statutory confidentiality provision, the licensing authority may share information with child support services through manual or automated means for the sole purpose of identifying applicants or licensees subject to enforcement under Iowa Code chapter 252J or 598.

These rules are intended to implement Iowa Code chapter 252J.

ARC 9658C

PUBLIC SAFETY DEPARTMENT[661]

Notice of Intended Action

Proposing rulemaking related to ignition interlock devices and providing an opportunity for public comment

The Department of Public Safety hereby proposes to rescind Chapter 158, "Ignition Interlock Devices," Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 321J.4(8)"b" and 2024 Iowa Acts, Senate File 2261.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 321J.

Purpose and Summary

The purpose of this proposed chapter is to establish standards and requirements that apply to ignition interlock devices (IIDs) installed on motor vehicles pursuant to court orders or administrative orders issued by the Department of Transportation (DOT) pursuant to Iowa Code chapter 321J. Various sections of Iowa Code chapter 321J require drivers who have been convicted of violating or administratively adjudged to have violated certain provisions of Iowa Code chapter 321J to have ignition interlock devices "of a type approved by the commissioner of public safety" installed on their vehicles in order to maintain their driving privileges. The rules in this proposed chapter provide the standards for such approval.

This proposed chapter is also incorporating necessary changes as a result of 2024 Iowa Acts, Senate File 2261.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 23, 2025. A public hearing was held on the following date(s):

- August 12, 2025

The Department received comments from Smart Start, a manufacturer of IIDs. Smart Start made several suggestions related to definitions and related verbiage, many of which the Department concurred with and thus adopted most of the recommendations.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 661—Chapter 10.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 3, 2025. Comments should be directed to:

Josie Wagler
Department of Public Safety
Oran Pape State Office Building
215 East 7th Street
Des Moines, Iowa 50319
Phone: 515.725.6185
Email: wagler@dps.state.ia.us

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	First Floor Public Conference Room 125 Oran Pape State Office Building 215 East 7th Street Des Moines, Iowa

December 3, 2025 2:30 to 3 p.m.	First Floor Public Conference Room 125 Oran Pape State Office Building 215 East 7th Street Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 661—Chapter 158 and adopt the following **new** chapter in lieu thereof:

CHAPTER 158
IGNITION INTERLOCK DEVICES

661—158.1(321J) Scope and authority.

158.1(1) The rules in this chapter establish standards and requirements that apply to ignition interlock devices installed in motor vehicles pursuant to court orders or administrative orders issued by the DOT pursuant to Iowa Code chapter 321J.

158.1(2) Various sections of Iowa Code chapter 321J require drivers who have been convicted of violating or administratively adjudged to have violated certain provisions of Iowa Code chapter 321J to have ignition interlock devices "of a type approved by the commissioner of public safety" installed on their vehicles in order to continue to drive legally. The rules in this chapter provide the standards for such approval.

661—158.2(321J) Definitions. The following definitions apply to rules in this chapter:

"Alcohol" means any member of the class of organic compounds known as alcohols and, specifically, ethyl alcohol.

"ASP" means an authorized service provider, which is a person or company meeting all qualifications outlined in this chapter and approved and trained by the manufacturer to service, install, monitor or calibrate IIDs approved pursuant to this chapter.

"BrAC" means breath alcohol concentration, which is the amount of alcohol determined by chemical analysis of the individual's breath measured in grams of alcohol per 210 liters of breath.

"Bypass," "bypassing" or *"tampering"* means the attempted or successful circumvention of the proper functioning of an IID, including but not limited to the push start of a vehicle equipped with an IID; disabling, disconnecting or altering an IID; or introduction of a breath sample into an IID other than a nonfiltered direct breath sample from the driver of the vehicle in order to defeat the intended purpose of the IID.

"Confirmatory test" means a breath alcohol test required in response to a bypass or a first failed test.

"DCI" means the Iowa division of criminal investigation.

"DOT" means Iowa department of transportation, office of driver services.

"Fail level" means a BrAC equal to or greater than 0.04 grams per 210 liters of breath, at which level the IID will prevent the vehicle from starting or will indicate a violation once the vehicle is running.

"First failed test" means providing a breath sample to an ignition interlock device with an alcohol concentration of 0.04 or more.

"IID" means ignition interlock device, which is an electronic device that is installed in a vehicle and that requires the completion of a breath sample test prior to starting the vehicle and at periodic intervals after the vehicle has been started. If the IID detects an alcohol concentration of 0.04 grams or greater per 210 liters of breath, the vehicle will be prevented from starting.

"Initial test" means a breath sample that is collected in an attempt to start a vehicle.

"Laboratory" means the division of criminal investigation criminalistics laboratory.

"Lessee" means a person who has entered into an agreement with a manufacturer or an ASP to lease an IID and whose driving privileges are contingent on the use of an IID.

"Lockout" means a condition in which the IID will not accept a breath test.

"Lockout override" means a method of unlocking a device to accept a breath sample.

"Manufacturer" means the person, company, or corporation that produced the IID.

"Random retest" means a breath sample that is collected in a nonscheduled, random manner after the vehicle has been started.

"Start or starting" means to manipulate a vehicle's inputs or systems or to activate a motor, thereby initiating the transition of a stationary vehicle into a motor-powered, driver-controlled motion.

"User" means a person operating a vehicle equipped with an IID.

"Violation" means a violation as described in Iowa Code section 321J.17A(4).

"Violation reset" means a required calibration check and recalibration in accordance with subrule 158.8(1) when the device has a recorded violation.

661—158.3(321J) Approval. To be approved, an IID will meet or exceed performance standards contained in the Model Specifications for Breath Alcohol Ignition Interlock Devices as published in the Federal Register, May 8, 2013, Volume 78, No. 89 pages 26849-26867. Only a notarized statement from a laboratory capable of performing the tests specified will be accepted as proof of meeting or exceeding the standards.

158.3(1) In addition to the federal standards, the laboratory will apply scientific tests or methods to a particular IID to determine whether it meets an acceptable standard for accuracy.

158.3(2) At the discretion of the laboratory administrator, the laboratory may accept test results from other public laboratories or authorities.

158.3(3) A list of IIDs approved by the commissioner of public safety will be maintained by the laboratory. The list is available without cost by writing to the Iowa Department of Public Safety, Division of Criminal Investigation, Criminalistics Laboratory, 2240 South Ankeny Boulevard, Ankeny, Iowa 50023; by telephoning 515.725.1500; or by accessing the list on the laboratory's website.

NOTE: As of May 1, 2024, the website of the laboratory is breathalcohol.iowa.gov.

661—158.4(321J) Revocation of approval.

158.4(1) The approval of an IID will remain valid until either voluntarily surrendered by the manufacturer or until the approval of the IID has been revoked by the commissioner of public safety for cause. Reasons for revocation include but are not limited to the following:

a. Evidence of repeated IID failures due to defects in design, materials, or workmanship during manufacture, installation, monitoring, or calibration of the IID such that the accuracy of the IID or the reliability of the IID as approved is not being met as determined by the laboratory.

b. A pattern of evidence that the mandatory operational features of the IID as described in rule 661—158.6(321J) are not functioning properly.

c. A pattern of evidence indicating that the IID may be easily tampered with or bypassed.

d. Any violation on the part of the manufacturer of the IID of any laws or regulations related to the installation, servicing, monitoring, and calibration of IIDs, or failure of a manufacturer to address repeated violations by an ASP.

e. Cancellation of the manufacturer's required liability insurance coverage.

f. Cessation of business operations by the manufacturer.

g. Failure to notify the laboratory in writing of any material modifications or alterations to the components or the design of the approved IID.

h. Failure of the manufacturer or an ASP to notify the DOT and the county attorney of the county of residence of the lessee within 30 days of the discovery of evidence of tampering with or attempting to bypass an IID.

i. Evidence that the manufacturer or ASP(s), or its owners, employees, or agents, has committed any act of theft or fraud, deception or material omission of fact related to the distribution, installation, or operation of any IID subject to this chapter.

j. Revocation of approval in another state for any of the reasons for revocation listed in paragraphs 158.4(1)*"a"* through *"i."*

158.4(2) A revocation will be effective 30 days from the date of the letter sent to the manufacturer via certified mail, return receipt requested, unless otherwise specified by the commissioner. A copy of each notice of revocation will be provided to the director of the DOT.

158.4(3) Upon voluntary surrender or revocation, all IIDs subject to surrender or revocation will be removed and replaced by an approved IID within 60 days of the effective date of such surrender or revocation. The manufacturer or the ASP will notify all affected lessees of the surrender or revocation and the requirement that a new IID will be installed by an existing ASP within the time frame specified in this subrule.

158.4(4) A revocation of a previously approved IID may be appealed to the department of public safety by the filing of an appeal in accordance with the procedures specified in rule 661—10.101(17A) within ten days of the issuance of the notice of revocation.

661—158.5(321J) Modifications to an approved IID. The manufacturer will inform the laboratory in writing of any modifications that will affect the accuracy, reliability, ease of use, or general function of the approved IID. The notification will include but not be limited to a listing of those modifications that were made, those components that were redesigned or replaced, and any additional alterations. Each of these changes should also include a narrative explaining how the modifications or alterations will affect the accuracy, reliability, ease of use, or general function of the IID. The laboratory reserves the right to test the IID to determine if the IID meets or exceeds the requirements established in this chapter.

661—158.6(321J) Mandatory operational features. In addition to any requirements established elsewhere in this chapter, an approved IID will comply with the following:

158.6(1) The IID will be designed and constructed to measure a person's BrAC by utilizing a sample of the person's breath delivered directly into the IID. A minimum volume of 1.5 liters of continuously delivered breath is required for acceptance but may be lowered to 1.2 liters of continuously delivered breath with a medical waiver provided to the department.

158.6(2) The IID will be designed and constructed so that the ignition system of the vehicle in which it is installed will not be started if the BrAC of the person submitting the initial test is 0.04 BrAC or more.

158.6(3) The IID will lock out if the IID has not been calibrated within 67 days subsequent to the last calibration. Calibration may be required more frequently at the discretion of the manufacturer or the ASP. The laboratory administrator may approve a device using fuel cell technology to be recalibrated within 187 days of the previous calibration provided that the device passes specific precision and functionality testing approved by the laboratory administrator and carried out by the laboratory or an independent laboratory acceptable to the laboratory administrator. A lockout override may be utilized to unlock a device for a period of three hours.

158.6(4) The IID will require a confirmatory test in response to a failed first test or bypass. The device will allow two minutes for the confirmatory test to be completed. Once a confirmatory test is in progress, either (1) failing to provide a detectable breath sample to the IID when prompted by the device or (2) providing a breath sample to the IID with an alcohol concentration or 0.04 or more will be recorded as a violation and, if in response to a bypass or random retest, cause the device to immediately notify peace officers as prescribed in this rule and disable the sample-free start.

158.6(5) The IID will record every instance when the vehicle is started, the results of the breath sample test, how long the vehicle was operated, and any indications that the IID may have been tampered with or bypassed.

158.6(6) The IID will require the operator to submit to a random retest within ten minutes of starting the vehicle. A minimum of two additional random retests will occur within 60 minutes of starting the vehicle, and a minimum of two random retests will occur within every 60 minutes thereafter. The device will allow six minutes for the random retest to be completed. Random retests may be achieved during operation of the vehicle.

158.6(7) The IID will permit a sample-free restart for a maximum period of two minutes unless the IID has initiated a random retest, in which case the operator will successfully perform a breath sample test before the vehicle may be restarted.

158.6(8) The IID will automatically and completely purge residual alcohol before allowing subsequent tests.

158.6(9) The IID will be installed in such a manner that it will not interfere with the normal operation of the vehicle after the vehicle has been started.

158.6(10) The IID will be equipped with a method of immediately notifying peace officers if the retest required by subrule 158.6(6) is not performed or if the result of a random retest exceeds the alcohol concentration of 0.04 BrAC. Examples of acceptable forms of notification are repeated honking of the vehicle's horn and repeated flashing of the vehicle's headlights. Such notification may be disabled only by switching the engine off or by achievement of a retest at a level below 0.04 BrAC.

158.6(11) Each IID will be uniquely identified by a serial number. Along with any other information required by the DOT or by an originating court, all reports to the DOT or to an originating court concerning a particular IID will include the name, address, and driver's license number of the lessee and the unique serial number of the IID. The name, address, telephone number, and contact person of the manufacturer or the ASP furnishing the report will also be included as part of the report.

661—158.7(321J) IID security.

158.7(1) The manufacturer and its ASPs will take all reasonable steps necessary to prevent tampering with or physical circumvention of the IID. These steps shall include the following:

a. ASPs will use special locks, seals, installation procedures, or design characteristics that prevent or record evidence of tampering or circumvention attempts.

b. The manufacturer or the ASP will affix a label to the IID indicating that attempts to tamper with or circumvent the IID may subject a person to criminal prosecution or administrative sanctions.

158.7(2) No owner or employee of a manufacturer or an ASP may authorize or assist with the disconnection of an IID or enable the use of any emergency bypass mechanism or any other bypass procedure that allows a person restricted to the use of a vehicle equipped with a functioning IID to start or operate a vehicle without providing all required breath samples. Authorizing or assisting with the disconnection of an IID may subject the owner or employee of a manufacturer or an ASP to criminal prosecution or administrative sanctions.

661—158.8(321J) IID maintenance and reports.

158.8(1) An IID utilized in accordance with the provisions of this chapter will have the calibration checked and recalibrated at least once every 60 days or pursuant to a violation reset using either a wet bath simulator or dry gas standard. Calibration is to be completed by the manufacturer or the ASP. In lieu of calibration of an installed IID, an installed IID may be exchanged for another calibrated IID. The laboratory administrator may approve a device that employs fuel cell technology to be used for up to 180 days from the date of the previous calibration provided that the device passes specific precision and functionality testing approved by the laboratory administrator and carried out by the laboratory or an independent laboratory acceptable to the laboratory administrator. An IID will automatically enter a lockout condition if the IID has not been calibrated within seven days of a violation reset or after the deadlines established in this subrule.

158.8(2) The calibration record for the IID currently installed in a vehicle pursuant to Iowa Code section 321J.4 and this chapter and for any other IID installed in the same vehicle will be maintained by the manufacturer or the ASP. The record will include the following:

a. Name of the person performing the calibration;
b. Date;
c. Value and type of standard used;
d. Batch or lot number of standard;
e. Unit type and identification number of the IID; and
f. Description of the vehicle in which the IID is installed, including:
(1) Registration plate number and state;
(2) Make;
(3) Model;
(4) Vehicle identification number;
(5) Year; and
(6) Color.

158.8(3) The IID will be calibrated for accuracy according to the manufacturer's procedures. All data contained in the IID's memory will be downloaded, and the manufacturer or the ASP will make a hard copy or the electronic equivalent of a hard copy of client data and results of each examination.

158.8(4) All information obtained as a result of each inspection will be retained by the manufacturer or the ASP for five years from the date the IID is removed from the vehicle.

158.8(5) Any manufacturer or ASP who discovers evidence of tampering with or attempting to bypass an IID will, within 30 days of the discovery, notify the DOT and the county attorney of the county of residence of the lessee of that evidence.

158.8(6) The manufacturer or the ASP will provide, upon request, additional reports in a format acceptable to, and at no cost to, the DOT and the DCI.

158.8(7) The manufacturer or the ASP will notify the DOT within ten days if an IID is not calibrated within the time period specified in subrule 158.6(3).

661—158.9(321J) Other provisions. In addition to any other applicable provisions of this chapter, each manufacturer of an approved IID, either on its own or through its ASPs, will comply with the following provisions:

158.9(1) Each manufacturer and ASP of IIDs approved for use in Iowa pursuant to this chapter will maintain general liability insurance coverage that is effective in Iowa and that has been issued by an insurance carrier authorized to operate in Iowa by the Iowa division of insurance in an amount of not less than $1 million per occurrence and $3 million in the aggregate. Each manufacturer and ASP will furnish the DCI with proof of this insurance coverage in the form of a certificate of insurance from the insurance company issuing the policy. All insurance policies required by this subrule will carry an endorsement requiring that the DCI be provided with written notice of cancellation of insurance coverage required by this subrule at least ten days prior to the effective date of cancellation.

158.9(2) Each manufacturer of IIDs approved for use in Iowa will maintain an email address and a telephone number that are available 24 hours a day, 365 days a year, for lessees or users to contact the manufacturer or the ASP if lessees or users have problems with the IID leased from the manufacturer or the ASP.

158.9(3) Each manufacturer of IIDs approved for use in Iowa will provide the lessee with instructions on how to properly use the IID, including recommending a 15-minute waiting period between the last drink of an alcoholic beverage and the time of breath sample delivery into the IID.

158.9(4) An IID utilized under these rules will be installed and removed by the manufacturer or the ASP in conformance with the prescribed procedures of the manufacturer.

158.9(5) The department of public safety reserves the right to inspect any IID, manufacturer, or ASP at any time at the department's discretion. All records of IIDs installed, results of calibrations, violations, data logs, and results of known alcohol standards will be made available for inspection upon request to any representatives of the department of public safety or DOT or any peace officer.

These rules are intended to implement Iowa Code chapter 321J.

REVENUE DEPARTMENT

Interest Rates

Starting January 1, 2026, the interest rate for taxpayers with overdue payments will be:

- 10.0% annually
- 0.8% monthly
- 0.027397% daily

Iowa Code section 421.7 specifies the procedures for calculating the Department's annual and monthly interest rates. The annual rate is based on the average monthly prime rate during the preceding 12-month period (October through September). Iowa law requires that this average be rounded to the nearest whole percent and two percentage points to be added to it. The prime rate averaged 7.57 percent over the past 12 months. Rounded to the nearest whole percent, this average is 8.0 percent. Adding two percentage points results in the annual Department rate of 10.0 percent. The monthly rate is the annual rate divided by 12, rounded to the nearest one-tenth of a percentage point. The daily rate for 2026 is the annual rate divided by 365. (The average monthly bank prime rate is published by the United States Federal Reserve at www.federalreserve.gov/datadownload/Choose.aspx?rel=H15.)

ARC 9661C

VOLUNTEER SERVICE, IOWA COMMISSION ON[817]

Notice of Intended Action

Proposing rulemaking related to sexual orientation and gender identity—Iowa youth mentoring program and the future ready Iowa volunteer mentor program and providing an opportunity for public comment

The Iowa Commission on Volunteer Service hereby proposes to amend Chapter 8, "Iowa Youth Mentoring Program Certification," and Chapter 13, "Future Ready Iowa Volunteer Mentor Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in 2025 Iowa Acts, Senate File 418.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2025 Iowa Acts, Senate File 418.

Purpose and Summary

The purpose of this proposed rulemaking is to update language in agency [817] chapters to conform to changes made in 2025 Iowa Acts, Senate File 418.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 1, 2025. A public hearing was held on the following date(s):

- October 21, 2025

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department of Health and Human Services for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Department no later than 4:30 p.m. on December 2, 2025. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: victoria.daniels@hhs.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz
December 2, 2025 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 214 710 328 674 4 Passcode: 2jG72at2

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Amend paragraph **8.4(4)"d"** as follows:

d. Suitability criteria that relate to the program's statement of purpose and needs of the target population. Criteria may include some or all of the following: personality profile, skills identification,

~~gender~~ sex, age, language, racial requirements, level of education, career interests, motivation for volunteering, and academic standing.

ITEM 2. Amend paragraph **8.4(6)"c"** as follows:

c. Appropriate criteria for matches, including some or all of the following: ~~gender~~ sex, age, language requirements, availability, needs, interests, preferences of volunteer and participant, life experience, and temperament.

ITEM 3. Amend rule 817—13.3(15H) as follows:

817—13.3(15H) Program standards, guidelines, and expectations. The commission will maintain on its website standards, guidelines, and expectations for a productive and appropriate relationship between volunteer mentors and student mentees. Standards, guidelines, and expectations are aimed at helping students meet the last-dollar scholarship or grant program requirements, identify work-based learning opportunities, and make career-related connections that are advantageous to participants in the program through a healthy mentor-mentee relationship. Failure to adhere to the program standards may result in ineligibility to participate in the program. To the extent possible, volunteer mentors and student mentees will be matched based on ~~gender~~ sex, career aspirations, geography and mentor-to-mentee ratio.

ARC 9695C

APPEAL BOARD, STATE[543]

Adopted and Filed

Rulemaking related to general provisions

The State Appeal Board hereby rescinds Chapter 1, "Tort Claims," and adopts a new Chapter 1, "General Provisions," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapter 25 and sections 24.26 and 24.30 through 24.32.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 25 and sections 24.26 and 24.30 through 24.32.

Purpose and Summary

The Board is rescinding Chapter 1 and replacing it with new rules in a new structure. The current chapter includes definitions, information about the Board, and the form and content submission obligations for tort claims. The Board plans to restructure its rules entirely to make the entire set of rules easier to follow.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on August 6, 2025, as **ARC 9460C**. A public hearing was held on the following date(s):

- August 29, 2025
- September 5, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Board on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting.

The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 543—Chapter 1 and adopt the following **new** chapter in lieu thereof:

CHAPTER 1
GENERAL PROVISIONS

543—1.1(669) Definitions.

"Award" means the same as defined in Iowa Code section 669.2.

"Board" means "state appeal board" as defined in Iowa Code section 24.26.

"Board's mailing address" means State Capitol Building, 1007 East Grand Avenue, Room G13, Des Moines, Iowa 50319.

"Claim" means the same as defined in Iowa Code section 669.2.

"Department" means the department of management.

"Director" means the director of the department.

"Employee of the state" means the same as defined in Iowa Code section 669.2.

"Executive secretary" means executive secretary of the board.

"State agency" means the same as defined in Iowa Code section 669.2.

543—1.2(17A) Organization. The board is a unit of government within the department. The board oversees claims made against the state. Correspondence to the board should be sent to the board's mailing address. Requests for information about the board may be made to the executive secretary at the board's mailing address. The three voting members of the board are:

1. Treasurer of state. Telephone: 515.281.5366.
2. Auditor of state. Telephone: 515.281.5834.
3. Director of the department. Telephone: 515.281.3322.

543—1.3(669) Meetings of the board. The board will meet at a time and place fixed by the chairperson or a quorum of the board.

1.3(1) *Session.* The board will be considered in continuous session for the purpose of entering orders, issuing determinations, and making awards.

1.3(2) *Quorum.* A majority of board members constitutes a quorum of the board. All decisions of the board may be made by a quorum of the board.

1.3(3) *Executive secretary.* The director will appoint an employee of the department to serve as the executive secretary.

These rules are intended to implement Iowa Code chapter 17A and section 25.2.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9696C

APPEAL BOARD, STATE[543]

Adopted and Filed

Rulemaking related to tort claims

The State Appeal Board hereby rescinds Chapter 2, "General Provisions," and adopts a new Chapter 2, "Tort Claims," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapter 25 and sections 24.26 and 24.30 through 24.32.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 25 and sections 24.26 and 24.30 through 24.32.

Purpose and Summary

The Board is rescinding Chapter 2 and replacing it with new rules in a new structure. The current structure of the Board's chapters includes some background information about the Board in existing 543—Chapter 1 and other components in existing Chapter 2. Existing 543—Chapter 1 also includes rules addressing how individuals submit tort claims. The blending of concepts in different chapters was deemed confusing and unworkable going forward, so 543—Chapters 1 and 2 are being replaced, with the new 543—Chapter 1 setting out general background information about the Board and the new Chapter 2 dedicated to tort claims, which represent the highest volume of appeals seen by the Board. This restructuring is intended to make it easier for citizens seeking to interact with the Board to find the information they need to do so.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on August 6, 2025, as **ARC 9461C**. A public hearing was held on the following date(s):

- August 29, 2025
- September 5, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Board on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 543—Chapter 2 and adopt the following **new** chapter in lieu thereof:

CHAPTER 2
TORT CLAIMS

543—2.1(669) Form of claims.

2.1(1) *Place of filing.* Tort claims will be filed with the executive secretary at the board's address. The board may make forms available to facilitate submission of a claim.

2.1(2) *Names, signatures, and verification.* To be valid, a claim needs to be legible and state the name, address, telephone number, and age of the person making the claim; the name, address and telephone number of the claimant's attorney preparing the claim, if any; and their signatures. Claims must also be verified as being true and that the information provided is accurate to the best of the claimant's knowledge.

2.1(3) *Designation by number.* The executive secretary will assign a number to each claim. Thereafter, claims may be referred to by the assigned number.

543—2.2(669) Content. Valid claims need to include all information as required by the board's official submission form.

543—2.3(669) Attorney general. The executive secretary will convey each claim to the special assistant attorney general assigned to the board. The special assistant attorney general will investigate the claim and is empowered to administer oaths, take testimony, and conduct discovery in accordance with the Iowa Rules of Civil Procedure. The special assistant attorney general may compel the attendance of witnesses and certify to any district court for contempt.

543—2.4(669) Notification. The special assistant attorney general will notify the claimant or the claimant's attorney, in writing, of the board's determination and any award.

543—2.5(669) Release. The claimant is obligated to execute a release of the claim and covenant not to sue in consideration of acceptance of the award.

543—2.6(669) Acceptance. Return of the executed release and covenant not to sue will constitute acceptance of the award in full settlement of the claim.

543—2.7(669) Warrant. Upon acceptance of the award, completion of the release, and a determination by the board that attorneys' fees requested are reasonable, the board will issue a warrant in the agreed amount, payable to claimant and the claimant's attorney.

543—2.8(669) Withdrawal. Submitted claims may be withdrawn at any time through written notice addressed to the board at the board's mailing address.

These rules are intended to implement Iowa Code chapter 17A and section 669.3(3).

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9697C

APPEAL BOARD, STATE[543]

Adopted and Filed

Rulemaking related to general claims

The State Appeal Board hereby rescinds Chapter 3, "General Claims," Iowa Administrative Code, and adopts a new Chapter 3 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

Purpose and Summary

The Board is rescinding and repromulgating Chapter 3. The statements in the existing chapter were evaluated to ensure the rules were minimally necessary to convey to the public information on how to submit a general claim to the Board and information applicable to the Board's action on that claim. The rules were updated to apply new definitions, remove restrictive words and phrases, and remove any antiquated concepts.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on August 6, 2025, as **ARC 9464C**. A public hearing was held on the following date(s):

- August 29, 2025
- September 5, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Board on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any

individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 543—Chapter 3 and adopt the following **new** chapter in lieu thereof:

CHAPTER 3
GENERAL CLAIMS

543—3.1(25) Claims. General claims include but are not limited to the listing of claims found in Iowa Code section 25.2. General claims will be filed on a form supplied by the board's executive secretary. Claims will be filed with and processed directly by the state agency allegedly responsible for payment when the claim is for an outdated invoice that is from a previous fiscal year and the amount of the reversion is sufficient to pay the claim. If a claim meets this criteria, then the agency will recommend approval of the claim. The claim is then to be submitted to the department of administrative services state accounting enterprise, which will process such claims. The state agency will keep a record of such claims and will report to the board at the board's next regularly scheduled meeting. The claim will be submitted to the department of administrative services state accounting enterprise on the form prescribed by the board. The department of administrative services state accounting enterprise is authorized by the board to pay such claims from the board appropriation if sufficient moneys have been reverted from the state agency involved. If sufficient moneys have not been reverted, or if the state agency or the department of administrative services state accounting enterprise recommends denial of the claim, the claim is to be forwarded by the state agency to the board for consideration. A record of denied claims will be submitted quarterly to the board by the state agency.

3.1(1) *Place of filing.* The original and one copy of the general claim should be addressed to the board's mailing address.

3.1(2) *Names and signatures.* General claims will state the name, address and telephone number of the claimant and be signed.

3.1(3) *Designation.* A general claim will indicate that it is a general claim filed pursuant to Iowa Code chapter 25.

3.1(4) *Designation by number.* The executive secretary of the board will assign a number to each general claim. Thereafter, the claim may be referred to by such number. If a claim meets the conditions for direct state agency adjudication of the claim, a number will not be assigned.

543—3.2(25) Content. All general claims will set forth information as follows.

3.2(1) *Services rendered or merchandise purchased.* An itemized statement indicating the services or merchandise, the name of the state agency or employee involved, and, if available, a bill for the same will be attached.

3.2(2) *Refunds.* A detailed statement of the reasons for the refund, indicating the state agency involved, will be attached.

3.2(3) *Documentation.* Sufficient documentation to support the claim will be attached.

3.2(4) *Amount.* All amounts for which the claim is filed will be stated and itemized.

543—3.3(25) Investigation. The special assistant attorney general assigned will investigate a general claim. The special assistant attorney general may administer oaths and may take testimony and conduct discovery in accordance with the Iowa Rules of Civil Procedure, Division V. The special assistant attorney general may compel the attendance of witnesses and certify to any district court for contempt. All information from the investigation will be included with the report to the board.

543—3.4(25) Notification. The special assistant attorney general will notify the claimant or the claimant's attorney, in writing, of the board's determination and any award.

543—3.5(25) Warrant. Upon acceptance of the award, the board will issue a warrant in the agreed amount, payable to claimant or the claimant's attorney.

543—3.6(25) Withdrawal. Submitted claims may be withdrawn at any time through written notice addressed to the board at the board's mailing address.

These rules are intended to implement Iowa Code chapter 25.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9698C

APPEAL BOARD, STATE[543]

Adopted and Filed

Rulemaking related to budget appeals

The State Appeal Board hereby adopts new Chapter 4, "Budget Appeals," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

Purpose and Summary

The Board is repromulgating the rules in existing 543—Chapter 5 as a new Chapter 4. 543—Chapter 5 is being rescinded herein (IAB 11/12/25), and the new Chapter 4 is being adopted. The statements in the existing 543—Chapter 5 were evaluated to ensure the rules were minimally necessary to convey to the public information on how to submit a budget appeal to the Board and information applicable to the Board's action on that claim. The rules were updated to apply new definitions, remove restrictive words and phrases, and remove any antiquated concepts. Rules that were in 543—Chapter 5 that were not directly related to budget appeals were relocated to ensure the focus of the proposed Chapter 4 remained on budget appeals and not ancillary matters.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on August 6, 2025, as **ARC 9465C**. A public hearing was held on the following date(s):

- August 29, 2025
- September 5, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Board on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 543—Chapter 4:

CHAPTER 4
BUDGET APPEALS

543—4.1(24) Budget appeals. In resolving appeals filed under Iowa Code chapter 24, the board possesses broad discretionary power to determine how objections are presented and the conduct of hearings and appeals. All proceedings will be simple and informal unless applicable law dictates formality.

543—4.2(24) Inquiries. Inquiries as to procedures may be directed to any board member at the members' respective telephone numbers or the executive secretary or board members at the board's address.

543—4.3(24) Filings.

4.3(1) The number of signatures needed for a budget appeal under Iowa Code chapter 24 is based on voting records. Voting record information is obtained from the county auditor (election commissioner). Verification of the signatures will be made by the board.

4.3(2) For a budget or amendment appeal for all local governments other than a city, the appeal has to be signed by a number of persons in the municipality (local government) equal to one-fourth of 1 percent of those voting for the office of president of the United States or governor, as the case may be, at the last general election in said municipality, but the number will not be less than 10, and the number need not be more than 100 persons.

4.3(3) For a city budget or amendment appeal, the protest has to be signed by qualified electors equal in number to one-fourth of 1 percent of the votes cast for governor in the last preceding general

election in the city, but the number will not be less than 10 and the number need not be more than 100 persons.

4.3(4) Filings of appeal petitions are to be with the county auditor of the county in which the local government is located or, if more than one county is involved, in that county where the principal administrative offices are located.

4.3(5) It is the responsibility of the county auditor to notify the board and the appropriate local government upon receipt of an appeal petition. Such filing by the county auditor is to consist of a copy of the appeal petition, together with a complete copy of the certified budget under appeal. Filing with the board is through its executive secretary.

4.3(6) Any appeal and supporting documents will be legible. Copies of relevant documents are acceptable.

4.3(7) Signatures will be accompanied by legible and full mailing addresses.

4.3(8) Petitioners need not have appeared and entered objection at the public hearing at which the protested budget was considered.

4.3(9) The board will extend statutory deadlines by the same elapsed time constraints when tardy certification occurs or whenever a different certification date is established by a special charter city.

4.3(10) If more than one appeal with reasonably related issues is filed against the same budget, the board may consolidate or concurrently consider the appeals in a single hearing and may issue a consolidated decision.

4.3(11) Appeals may be submitted in any form. The content of the appeal should include:

a. Name of the local government budget being appealed.

b. Statutory authority under which the appeal is taken (Iowa Code chapter 384 for cities and Iowa Code chapter 24 for all other local governments).

c. Decision being protested, summarizing key objections and basic reasons for such objections.

This general statement may be expanded at the formal hearing with oral testimony, written briefs, exhibits or other substantive documentation.

4.3(12) Illustration of appeal format.

To: State Appeal Board
Iowa State Capitol
Des Moines, IA 50319

We, the undersigned, protest the action of the officials of ____(local government)____ in certification of their 20____–____ budget and request an appeal hearing.

We offer the following objections and reasons in summary form as basis for our appeal under Iowa Code chapter ____ :

Objection 1 (cite)
Reasons: (brief explanation)
Objection 2 (cite)
Reasons: (brief explanation)
(Add such other sections as needed to identify each basic objection and supporting reasons.)

Date	Signatures	Full mailing address with Zip code.
1. 2. 3. 10. 100.	(Additional signature sheets may be attached without the full heading, it being assumed those subscribing their names are fully aware of the stated appeal, objections and reasons. Minimal headings on attached sheets should indicate "Protest to _____(local government)_____ Budget, 20 ____–____.")	

4.3(13) The burden is upon objectors for any proposed item that was included in the budget of the previous year with proposal for reduction or exclusion of the specific items. These arguments need not be fully developed in the appeal petition.

4.3(14) The burden is on the local government certifying or levying officials (as opposed to staff) to show any new item in the budget, or any increase in any item thereof, is necessary, reasonable and in the interest of the public welfare.

543—4.4(24) Scheduling and notice of hearings.

4.4(1) Dates for hearings will be set by the board. When a date is set, notice will be given by certified mail, return receipt requested, to the first ten names on the petition and to the appropriate officials of the local government.

4.4(2) This notice will be mailed at least five days prior to the hearing.

543—4.5(24) Hearings.

4.5(1) Hearings will be held at scheduled times within the county where the local government is located or headquartered. All parties assume their own expenses except as may otherwise be specifically provided by rule or law.

4.5(2) The board may conduct the hearing or may appoint a deputy (hearing officer) to conduct the hearing and report findings and recommendations to the board for its decision.

4.5(3) The hearing will be held in a public place and will be open to the public. The hearing will be conducted so as to give all parties a fair opportunity to be heard.

4.5(4) The board's executive secretary will prepare an official record of all proceedings, including testimony and exhibits. Testimony taken by a mechanical recording device may be incorporated by reference if a transcript is not made. A reasonable amount will be charged to cover the cost of providing a duplicate tape or a copy of the transcription for either party. Tapes will be retained for five years following the decision.

4.5(5) If a party entitled to a hearing fails to appear, that party will be deemed to have waived opportunity for the hearing or to participate in the hearing unless there is good cause for such failure.

4.5(6) Legal counsel will be at the discretion and expense of either party to the appeal.

4.5(7) Parties appearing before the board should select one or two persons to serve as primary spokespersons for their position.

4.5(8) The board will exclude evidence that is irrelevant, immaterial or unduly repetitious.

4.5(9) Written or printed materials will be in sufficient quantity to supply at least three copies for the board and one copy for the other party to the appeal.

4.5(10) Any party requesting a certified shorthand or court reporter will make arrangements for such attendance and expense.

4.5(11) At the outset of each hearing, the presiding board officer will indicate disposition of rulings on procedural questions and outline ground rules and time limitations to seek to give equal opportunity to both parties and basically permit:

a. Objectors' basic arguments.

b. Local government officials' basic arguments and rebuttal.

c. Rebuttal by objectors.

d. Presentation by authorized third party intervenors.

e. If desired, closing remarks by objectors.

f. If desired, closing remarks by local government officials.

g. Time permitting, comments by interested citizens.

h. Announcement as to adjournment, filing of additional briefs and the probable timing for the decision.

4.5(12) As deemed necessary, the board may examine the entire budget under appeal including cash reserves (balances), funding sources and expenditures of all types including actual or allowable transfers so those specific items under appeal may be fully examined and evaluated in perspective in arriving at a decision on the appeal.

4.5(13) The board will listen to testimony and arguments from all those concerned, take the matters under advisement, and make a decision setting out the findings of fact and conclusions of law on which the decision is based.

4.5(14) Board members or the presiding hearing officer will be free to ask questions of anyone at any point during any hearing.

4.5(15) The parties may agree upon pertinent facts in the proceedings by stipulation in writing filed at any stage in the proceedings or orally made at the hearing.

4.5(16) Any party served notice of hearing may seek to show cause for a continuance to a date certain at or before the time set for hearing.

4.5(17) The board may adjourn a hearing from time to time at its discretion.

4.5(18) Upon filing of a request by a third party to intervene, the board chairperson will determine whether the applicant has a legitimate interest in the proceedings and can contribute materially to the interpretation and settlement of the issues. Both original parties to the appeal will be advised of participation by a third party. If participation is denied, the written denial will include reasons for the denial.

4.5(19) If a K-12 school budget is appealed, that portion of expenditures attributable to the area education agency will be defended by a knowledgeable official of the area education agency.

4.5(20) At the conclusion of arguments, the board may entertain oral closing argument or additional briefing at its discretion.

4.5(21) Prior to a final decision, the board may reopen a hearing when new pertinent evidence becomes available that could not, with reasonable diligence, have been presented at the original hearing. This hearing need not be held in the county of original jurisdiction.

4.5(22) Any board member who has a possible conflict of interest in any matter resulting in a hearing will recuse themselves from serving during the hearing and from participation in the deliberations and decision resulting from the hearing. In the event one or more board members are recused, the board's decision will be made and issued by a majority of the remaining board members.

4.5(23) A member of the board does not have a conflict of interest by reason of residency within the geographical boundaries of the local government whose budget is appealed.

543—4.6(24) Decision.

4.6(1) The board will issue a written decision. The decision will include:

a. Identification of parties and basic issues.

b. Summary of findings of fact.

c. Summary of conclusions of law.

d. Decision.

e. Reasons for decision.

f. Order for implementation of the decision.

4.6(2) The board may approve, disapprove, or reduce items under appeal but in no event may it increase a budget, expenditure, tax levy or assessment or any item contained therein.

4.6(3) The decision is final and binding unless there is a rehearing or judicial review of the decision.

4.6(4) Either party may request rehearing, stating the specific grounds thereof and the relief sought, within 20 days after the issuance of the final decision. Such requests will be deemed denied unless the board sets a rehearing date within 20 days after the request is filed. This hearing need not be held in the county of original jurisdiction.

4.6(5) The board will notify the county auditor and both parties of the board's decision. Where other county auditors are affected, the county auditor is obligated to promptly inform the other county auditors of the board's decision and order.

543—4.7(24) Amendments.

4.7(1) Protests of amendments to budgets will be considered within the same general procedures and time constraints as are applicable to original budgets.

4.7(2) Any local budget has to be amended by May 31 of the current fiscal year to allow time for a protest hearing to be held and decision rendered before June 30. The amendment of a budget after May

31, that is properly appealed but without adequate time for hearing and decision before June 30, will be ruled null and void.

These rules are intended to implement Iowa Code sections 24.26 through 24.32.

[Filed 10/22/25, effective 12/17/25]
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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9699C

APPEAL BOARD, STATE[543]

Adopted and Filed

Rulemaking related to uniform rules

The State Appeal Board hereby rescinds Chapter 5, "Budget Appeals," and adopts a new Chapter 5, "Uniform Rules," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 24.26, 24.30 through 24.32 and 25.2, 10.

Purpose and Summary

Under the Board's current rules, numerous provisions sought to address concepts covered by the Uniform Rules on Agency Procedure. Guidance provided by the Governor's staff has been to use the Uniform Rules wherever possible and to only make minimal changes to those Uniform Rules where necessary. Applying that guidance, the Board plans to rescind existing 543—Chapters 6 and 7 and consolidate those concepts into a single new Chapter 5 focused on the Uniform Rules. The content of the existing Chapter 5 has been added to a new 543—Chapter 4 herein (IAB 11/12/25). This rulemaking rescinds the now-duplicative Chapter 5 and adopts this new Chapter 5 in its place. 543—Chapters 6 and 7 are being rescinded herein (IAB 11/12/25). The full set of Uniform Rules is being adopted by the Board, with internal references in those rules updated to reflect the Board's information or otherwise made to incorporate the rules into the Board's set of administrative rules. The only substantive provisions retained from current 543—Chapters 6 and 7 relate to fair information practices, where the Board's existing rules were thought to provide a benefit to the Board and citizens over the current Uniform Rules.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on August 6, 2025, as **ARC 9462C**. A public hearing was held on the following date(s):

- August 29, 2025
- September 5, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Board on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 543—Chapter 5 and adopt the following **new** chapter in lieu thereof:

CHAPTER 5
UNIFORM RULES

The board hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website.

543—5.1(17A,22) Fair information practices. The board hereby adopts, with the following exceptions and amendments, the uniform rules on agency procedure relating to fair information practices, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

5.1(1) In lieu of the words "(official or body issuing these rules)", insert "board".

5.1(2) In lieu of the word "agency", insert "board".

5.1(3) In lieu of the words "(insert agency head)", insert "chairperson of the board".

5.1(4) In lieu of the words "(insert agency name and address)", insert "the board at the board's mailing address".

5.1(5) In lieu of the words "(insert customary office hours and, if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays, and legal holidays".

5.1(6) In lieu of the words "(specify time period)", insert "30 minutes".

5.1(7) In lieu of the words "(An agency wishing to deal with search fees authorized by law should do so here.)", delete the statement.

5.1(8) In lieu of the words "(designate office)", insert "the board's executive secretary".

5.1(9) In lieu of the words "(and, where applicable, the time period during which the record may be disclosed)", insert "and, where applicable, the time period during which the record may be disclosed".

5.1(10) In lieu of the words "(Additional requirements may be necessary for special classes of records.)", insert "Additional obligations may be necessary for special classes of records".

5.1(11) In lieu of the words "(Each agency should revise its forms to provide this information.)", delete the statement.

543—5.2(17A,22) Additional fair information practices—uses and disclosures of information.

5.2(1) *General.* Board records are open for public inspection and copying unless otherwise provided by applicable law.

5.2(2) *Uses and disclosures of individually identifiable information.* To the extent allowed by law, uses or disclosures of confidential records may occur with or without the consent of the subject. Types of uses or disclosures that occur without the subject's consent include but are not necessarily limited to the following:

a. Use or disclosure for a routine use in relation to the work of the board, as long as such use or disclosure is made subject to the same confidentiality obligations imposed on the board.

b. Use or disclosure for statistical research purposes or reporting as long as the information is deidentified in advance.

c. Use or disclosure for civil or criminal law enforcement activities to the extent authorized by law.

d. Disclosure to an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual.

e. Disclosure to the legislative services agency under Iowa Code section 2A.3.

f. Use or disclosure in the course of employee disciplinary proceedings.

g. Use or disclosure in response to a court order or subpoena.

5.2(3) *Complaints to public officials.* A letter from a subject of a confidential record held by the board to a public official that seeks the official's intervention on behalf of the subject in a matter that involves the board will, to the extent permitted by law, be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

5.2(4) *Release to subject.* The subject of a confidential record may submit a request to review confidential records about that person. However, the board need not release the record to the subject to the extent that the record is confidential under applicable law. Records that may be declared confidential include but are not necessarily limited to records that are predecisional draft documents, peace officers' investigative reports, records that are subject to the attorney/client privilege, and records that are subject to the attorney work product doctrine. When a record has multiple identifiable subjects with interest in the confidentiality of the record, the board may take reasonable steps to protect confidential information relating to another subject.

543—5.3(17A) Petition for rulemaking. The board hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to petitions for rulemaking, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

5.3(1) In lieu of the word "agency", insert "board".

5.3(2) In lieu of the words "(designate office)", insert "board's mailing address".

5.3(3) In lieu of the phrase "designate official by full title and address", insert "chairperson of the board at the board's mailing address".

543—5.4(17A) Declaratory orders. The board hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to declaratory orders, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

5.4(1) In lieu of the words "designate agency", insert "board".

5.4(2) In lieu of the words "designate office", insert the "board's mailing address".

5.4(3) In lieu of the words "(An agency may wish to describe here a simplified alternative petition form that would be more appropriate for some members of its clientele in light of their particular circumstances.)", delete this sentence.

5.4(4) In lieu of the words "Within ____ days (15 or less)" found in rule X.2, insert "Within 15 days".

5.4(5) In lieu of the words "within ____ days of the filing of a petition" in rule X.3(1), insert "within 15 days of the filing of a petition".

5.4(6) In lieu of the words "(after time for notice under X.2(17A))", insert "15 days following receipt of notice from the board that a petition has been filed".

5.4(7) In lieu of the words "(agency name)", insert "board".

5.4(8) In lieu of the words "(specify office and address)", insert "the board at the board's mailing address".

5.4(9) In lieu of the words "(designate agency head)", insert "the chairperson of the board".

5.4(10) In lieu of the words "(uniform rule on contested cases X.12(17A))" and "(contested case uniform rule X.2(17A))", insert "uniform rule on contested cases X.12".

5.4(11) In lieu of the sentence "(The agency may specify any provisions of Iowa Code sections 17A.10 through 17A.18 on contested case proceedings to apply to proceedings for declaratory orders.)", delete the statement.

5.4(12) In lieu of the sentence "(Where the agency's experience enables it to define in advance other specific reasons for refusing to issue a declaratory order, it should include them here.)", delete the statement.

5.4(13) In lieu of the phrase "(who consent to be bound)", insert "who consent to be bound".

543—5.5(17A) Board procedure for rulemaking. The board hereby adopts, with the following exceptions and amendments, the Uniform Rules on Agency Procedure relating to agency procedure for rulemaking, which are published at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf on the general assembly's website. For purposes of this rule, the following designations are made:

5.5(1) In lieu of the words "(commission, board, council, director)", insert "board".

5.5(2) In lieu of the word "agency", insert "board".

5.5(3) In lieu of the words "(specify time period)", insert "one calendar year".

5.5(4) In lieu of the words "(identify office and address)", insert "the executive secretary at the board's mailing address".

5.5(5) In lieu of the words "(designate office and telephone number)", insert "the executive secretary at 515.281.3078".

5.5(6) In lieu of the words "(designate office)", insert "the board's mailing address".

5.5(7) In lieu of the words "(specify the office and address)", insert "the board's mailing address".

5.5(8) In lieu of the words "(agency head)", insert "chairperson of the board".

5.5(9) In lieu of the words "(Alternatively, the agency can maintain the file indefinitely.)" and "(*NOTE: Alternatively to X.13(2)"j" and the amendment of X.13(4), an agency could keep a separate file of significant written criticisms to rules and maintain those for five years.)", delete the statements.

5.5(10) In lieu of the words "(at actual cost)", insert "at actual cost".

These rules are intended to implement Iowa Code chapter 17A.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9700C

APPEAL BOARD, STATE[543]

Adopted and Filed

Rulemaking related to public records and fair information practices and agency procedure for rulemaking

The State Appeal Board hereby rescinds Chapter 6, "Public Records and Fair Information Practices," and Chapter 7, "Agency Procedure for Rule Making," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 24.26, 24.30 through 24.32 and 25.2.

Purpose and Summary

Under the Board's current rules, numerous provisions sought to address concepts covered by the Uniform Rules on Agency Procedure. Guidance provided by the Governor's staff has been to use the Uniform Rules wherever possible and to only make minimal changes to those Uniform Rules where necessary. Applying that guidance, the Board is rescinding and reserving Chapters 6 and 7 and has consolidated those concepts into a single new 543—Chapter 5 focused on the Uniform Rules. The new 543—Chapter 5 is adopted herein (IAB 11/12/25). This rulemaking simply rescinds Chapters 6 and 7.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on August 6, 2025, as **ARC 9463C**. A public hearing was held on the following date(s):

- August 29, 2025
- September 5, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Board on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **543—Chapter 6**.

ITEM 2. Rescind and reserve **543—Chapter 7**.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9701C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rulemaking related to refugee cash assistance

The Department of Health and Human Services hereby amends Chapter 60, "Refugee Cash Assistance," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapter 217.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 45 CFR 400.211; United States, Administration for Children and Families. "Office of Refugee Resettlement; Notice of Change of Eligibility," 90 Fed. Reg. 13,370 (March 21, 2025).

Purpose and Summary

This rulemaking amends subrule 60.7(1) to reflect federal updates to the eligibility period, or time limit, for receiving refugee cash assistance from 12 months to 4 months. The eligibility period is set by the procedures outlined in 40 CFR 400.211. The update to the eligibility period was published in the March 21, 2025, Federal Register.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025, as **ARC 9525C**. Public hearings were held on the following date:

- September 23, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 16, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on January 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Amend subrule 60.7(1) as follows:

60.7(1) *Assistance.* A refugee may receive assistance, if otherwise eligible:

a. For refugees who entered the country prior to October 1, 2021, during the first eight months the refugee is in the United States, beginning the month the refugee enters the country.

b. For refugees who entered the country on or after October 1, 2021, and for whom eligibility for refugee cash assistance was determined on or before May 4, 2025, during the first 12 months the refugee is in the United States, beginning the month the refugee enters the country.

c. For refugees who entered the country on or after October 1, 2021, and for whom eligibility for refugee cash assistance was determined on or after May 5, 2025, during the first four months the refugee is in the United States, beginning the month the refugee enters the country.

Exception: For asylees, the date of entry is the date asylum is granted. The 8-month, ~~or~~ 12-month, or 4-month period of eligibility begins the month asylum is granted. A nonrefugee child in the home with a refugee parent (or refugee parents, if both are in the home) is eligible for assistance until the parent(s) has been in the United States for 8, ~~or~~ 12, or 4 months, or until the child reaches 8, ~~or~~ 12, or 4 months of age, whichever occurs first. For Afghan special immigrant (SI) parolees and Afghan SI conditional permanent residents (CPRs), the date is the date of "entry into the community," which is the date the individual departed a safe haven. For Afghan humanitarian parolees, the date is the latter of October 1, 2021, or the date of entry into the community, which is the date the individual departed a safe haven. "Safe haven" is the term the U.S. government and other relevant stakeholders have used for U.S. military bases in the continental United States that housed Afghans evacuated under Operation Allies Refuge/Operation Allies Welcome (OAR/OAW) as Afghans awaited resettlement to their ultimate state of residence.

ITEM 2. Amend subrule 60.7(2) as follows:

60.7(2) *Resources.* The resources of refugees excluded because of the 8-month, ~~or~~ 12-month, or 4-month limit will be considered in the same manner as though these refugees were included in the eligible group.

[Filed 10/16/25, effective 1/1/26]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9702C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rulemaking related to enrollment and reenrollment

The Department of Health and Human Services hereby rescinds Chapter 76, "Enrollment and Reenrollment," Iowa Administrative Code, and adopts a new Chapter 76 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 514I and 42 CFR 435 and 457.

Purpose and Summary

This chapter underwent a Red Tape Review pursuant to Executive Order 10. The chapter specifies the process for enrolling and reenrolling in the Iowa Medical Assistance or "Medicaid" program and addresses related matters. Eligible individuals must be enrolled for the date on which services are provided in order for payment to be made for the services received.

Initial enrollment must be based on an application submitted to the Department (including for Hawki benefits), an application from the Federally Facilitated Marketplace (FFM), an express lane eligibility determination, a Supplemental Security Income (SSI) eligibility determination, a transmittal from the federal Social Security Administration for Medicare savings programs, or a presumptive eligibility determination as described in rules 441—76.2(249A) through 441—76.7(249A).

In addition to the elimination of restrictive terms and language duplicative of the Iowa Code or federal regulations, this rulemaking implements changes necessitated by the federal Patient Protection and Affordable Care Act of 2010.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9551C**. Public hearings were held on the following date:

- October 7, 2025

The Department received comments from two different organizations supporting many of the changes and making recommendations for changes to rules and to administrative processes.

As a result of those comments, changes from the Notice have been made to add a definition of "electronic data sources" or "EDS" in rule 441—76.1(249A) and to add language about notification of interviews to subrule 76.8(5).

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 7.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any

individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on January 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 441—Chapter 76 and adopt the following **new** chapter in lieu thereof:

CHAPTER 76
ENROLLMENT AND REENROLLMENT

441—76.1(249A) Definitions. The following definitions apply to this chapter in addition to the definitions in rule 441—75.1(249A).

"Act" or *"the Act"* means the federal Social Security Act, and all references herein are as amended to August 1, 2025.

"Authorized representative" means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, the review of eligibility and other ongoing communications with the department.

"Business hours" or *"HHS business hours"* means the hours between 8 a.m. and 4:30 p.m. Central Time during a weekday (Monday through Friday), excluding public holidays.

"Code of Federal Regulations" or *"CFR"* means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

"Electronic account" means a web-based account established by the department for an applicant or member for communication between the department and the applicant member.

"Electronic case record" means an electronic file that includes all information collected and generated by the department regarding each individual's Medicaid eligibility and enrollment.

"Electronic date sources" or *"EDS"* means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include the Internal Revenue Service (IRS), the Social Security Administration (SSA) and the United States Department of Homeland Security. State data sources include Iowa workforce development (IWD) wage and unemployment compensation, SSA, IRS, and the Public Assistance Reporting Information System (PARIS).

"Federally Facilitated Marketplace" or *"FFM"* means the health insurance marketplace established by the United States Secretary of Health and Human Services for states that choose not to set up their own marketplace or that do not get approval for one pursuant to 42 U.S.C. §18041.

"Federally Facilitated Marketplace referral" or *"FFM referral"* means an application submitted at healthcare.gov that requests help paying for health insurance. These applications are screened by the FFM and, if found to be potentially eligible for Iowa Medicaid or hawki, are transmitted via an electronic data file to the department for a final Medicaid/hawki determination.

"Health insurance marketplace" means a health insurance marketplace established pursuant to 42 U.S.C. §18031.

"Medicare savings program" refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are:

1. Qualified disabled and working people (QDWP) pursuant to 42 U.S.C. §1396a(a)(10)(E)(ii);
2. Qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(i);
3. Specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iii); and

4. Expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iv).

"Presumptive provider" means an organization approved by the department to conduct and authorize presumptive eligibility determinations as described in subrule 76.7(1).

"Qualified entity" means an individual, under the supervision and authority of a presumptive provider, approved by the department to conduct and authorize presumptive eligibility determinations.

"Responsible person" means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

"SSA" means the federal Social Security Administration.

"Supplemental Security Income" or *"SSI"* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

"United States Code" or *"U.S.C."* means the general and permanent laws of the United States. All references to U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.

"WIC" is the Special Supplemental Nutrition Program for Women, Infants, and Children established pursuant to 42 U.S.C. §1786.

441—76.2(249A) Application for medical assistance. This rule describes the process of applying for medical assistance from the department. Applications for Medicaid must be made as provided in this rule.

76.2(1) *Application with the department or qualified entity.*

a. Who can file. An application may be filed by:

(1) The applicant;

(2) An adult in the applicant's household, as described in 42 CFR §435.603(f), or family, as described in 26 CFR §1.36B-1(d), including:

1. A spouse as defined in rule 441—75.1(249A);

2. A parent of an applicant child, as defined in rule 441—75.1(249A), including either parent of an unborn child;

3. A caretaker of an applicant child, when the caretaker meets the requirements of rules 441—75.1(249A) and 441—75.51(249A); or

4. A tax-filer who claims the applicant as a dependent;

(3) An authorized representative described in subrule 76.9(2); or

(4) A responsible person described in subrule 76.9(1).

b. How and where to file.

(1) An application may be filed online on the department's website or www.healthcare.gov; at any local HHS office; or at any HHS outstation at a disproportionate share hospital, federally qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1.855.889.7985, or by email or fax to a local HHS office. Addresses, email addresses, and fax numbers of local HHS offices are available on the department's website.

(2) An application may also be filed at the office of a qualified entity pursuant to subrule 76.7(2), a WIC office, a maternal health clinic, or a well-child clinic.

c. Form. Applications for Medicaid, including Medicaid applications for foster care and subsidized adoption, may be submitted on forms prescribed by the department.

d. Minimum application requirements. Initial applications must contain a legible name and address and must be signed under penalty of perjury, pursuant to 42 CFR §435.907(f). At least one person listed in paragraph 76.2(1)*"a"* must sign the application. Electronic (including telephonically recorded) signatures and handwritten signatures (transmitted via any electronic means) are acceptable. An application that does not include a legible name, address, and signature under penalty of perjury will not be considered a valid application and will be rejected without a determination of eligibility.

76.2(2) *Date of filing.*

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1)*"b."*

b. Reserved.

c. The date of filing and effective date for applications received by a qualified entity for purposes of a presumptive Medicaid eligibility determination are further described in subrule 76.7(5).

d. The department will honor the application date of any application filed at the FFM that is subsequently transmitted to the department for an eligibility determination as described in rule 441—76.3(249A).

76.2(3) *Decision.* The department will notify the applicant of the eligibility decision pursuant to 441—Chapter 16.

441—76.3(249A) Referrals from the FFM. Upon receipt of an FFM referral indicating that an application has been screened and that the applicant has been found to be potentially eligible for Medicaid or hawki, the department will treat the application as if it had been received directly by the department pursuant to rule 441—76.2(249A).

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. §1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department will rely on a determination of the child's eligibility for the Supplemental Nutrition Assistance Program (SNAP) pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.3(2) except for citizenship or alienage requirements unless:

a. The child's household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income (MAGI) methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in SNAP eligibility since that time.

76.4(2) To obtain express lane enrollment for a child, the child's household must request medical assistance for the child on forms prescribed by the department. The department will send forms to the household when a child eligible for express lane enrollment is approved for SNAP pursuant to 441—Chapter 65. An adult member of the child's household or a child receiving SNAP benefits as head of household must sign the form and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child's SNAP effective date. Express lane eligibility begins on the first day of the month of the child's SNAP effective date.

76.4(5) After the initial express lane enrollment, all redeterminations of medical assistance eligibility will be made without reliance on any SNAP eligibility determination.

76.4(6) Retroactive enrollment is available pursuant to subrule 76.13(3) for any of the three months before the month of the child's SNAP effective date. The retroactive eligibility determination must be made without regard to SNAP eligibility.

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the SSA indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient may be required to provide additional information when necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information.

441—76.6(249A) Referral for Medicare savings program. Referrals received from the SSA pursuant to 42 U.S.C. §1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date

of the individual's application with SSA will be the application date for benefits under the Medicare savings program. When requested to do so, the applicant must complete a Medicare Savings Programs Additional Information Request form to provide additional information needed to determine Medicare savings program eligibility.

441—76.7(249A) Presumptive eligibility. Persons may be temporarily and immediately enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity at a presumptive provider pursuant to this rule.

76.7(1) *Presumptive provider.* A presumptive provider is an organization approved by the department to conduct and authorize presumptive eligibility determinations. A provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall do all of the following:

a. Complete the required self-directed policy and system training.

b. Apply to the department using the Application for Initial/Recertification to Be a Presumptive Provider form.

c. Read the Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations form and agree in writing to its terms.

d. Comply with the requirements outlined in Iowa's Medicaid state plan.

e. Meet the definition of "qualified provider" pursuant to 42 U.S.C. §1396r-1.

f. Meet the definition of "qualified entity" in the following federal regulations for the category of persons covered:

(1) For children under the age of 19, as described in 42 CFR §435.118, the provider must meet the requirements of paragraphs (1) through (10) of the definition of "qualified entity" in 42 CFR §435.1101;

(2) For pregnant women, as described in 42 CFR §435.116, the provider must meet the requirements of 42 U.S.C. §1396r-1(b)(2);

(3) For parents and caretakers, as described in 42 CFR §435.110, the provider must meet the requirements in 42 CFR §435.1103(b);

(4) For persons aged 19 through 64, as described in 42 CFR § 435.119, the provider must meet the requirements in 42 CFR §435.1103(b);

(5) For former foster care children, as described in 42 CFR §435.150, the provider must meet the requirements in 42 CFR §435.1103(b);

(6) For persons needing breast or cervical cancer treatment (BCCT), as described in 42 U.S.C. §1396r-1b(b)(2); and

(7) For all of the categories of persons covered in subparagraphs 76.7(1)*"f"*(1) through *"f"*(6), a qualifying hospital must meet the requirements in 42 CFR §435.1110(b).

g. Be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Application for Initial/Recertification to Be a Presumptive Provider form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding by signing in writing.

76.7(2) *Qualified entity.*

a. An individual that seeks to be authorized to make presumptive Medicaid eligibility determinations under the supervision and authority of a presumptive provider shall do all of the following:

(1) Complete the required self-directed policy and system training.

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal (MPEP) Access Request.

(3) Read the Provider Memorandum of Understanding and agree in writing to its terms.

(4) Obtain confirmation of acceptance by the department that the individual is determined by the department to be capable of making presumptive Medicaid eligibility determinations.

b. In addition to the requirements in paragraph 76.7(2)*"a,"* a qualified entity for BCCT must also have either:

(1) Been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department; or

(2) A cooperative agreement with the department under the Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act as amended to August 1, 2025, to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the care for yourself breast and cervical cancer early detection program.

c. Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations.

d. Qualified entities are required to be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal Recertification form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding in writing.

76.7(3) *How and where to file.* An applicant for presumptive Medicaid shall complete an application with a qualified entity in one of two ways:

a. Provide information in person to the qualified entity that enters the applicant's information into the MPEP system; or

b. Complete a paper application provided by the qualified entity that enters the applicant's information into the MPEP system.

76.7(4) *Signature.* An individual listed in paragraph 76.2(1)*"a"* must sign the completed paper application or a printed version of the completed MPEP application. A copy of the signed application must be maintained by the qualified entity.

76.7(5) *Date of filing and effective date of coverage.*

a. For purposes of determining the application date of filing for an ongoing eligibility determination, a paper application is valid only if it contains the applicant's legible name, address, and signature under penalty of perjury and must be date-stamped on the date it is received by the qualified entity. The date of filing as described in paragraph 76.2(2)*"a"* is used for purposes of determining the effective date of coverage for ongoing eligibility but does not determine the effective date of coverage for presumptive Medicaid.

b. The effective date of coverage for presumptive Medicaid is the date on which a qualified entity completes the presumptive eligibility determination within the MPEP system.

c. The applicant must provide to the qualified entity all information necessary to make a presumptive eligibility determination in the MPEP system.

76.7(6) *Notice and appeal rights.* The qualified entity shall inform the applicant of the eligibility decision as soon as possible but no later than two working days after the date the determination is made by the qualified entity. Timely and adequate notice requirements and appeal rights of the Medicaid program, including those outlined in 42 CFR Part 431, subpart E; Iowa Code chapter 17A; 441—Chapter 7; and 441—Chapter 16, do not apply to determinations of presumptive eligibility under this rule.

76.7(7) *Full medical assistance eligibility determination.* All presumptive eligibility applications will be given the option within the MPEP system to also receive a full determination of eligibility for Medicaid or hawki.

441—76.8(249A) Applicant and member responsibilities.

76.8(1) *Accurate information.* Clients, and those individuals acting on behalf of clients, are responsible for giving complete and accurate information needed to establish eligibility.

76.8(2) *Additional information or verification needed to determine eligibility.* An applicant or member will not be required to provide additional verifications if attested income meets the department's standards for reasonable compatibility and if the department can verify all other required information through an EDS. If attested income does not meet the department's standards for reasonable compatibility or if the department is not able to verify other required information through an EDS, the department will send the applicant or member a written request for the additional information or verification. The applicant or member must provide the additional information or verification by

the requested due date or such application may be denied or Medicaid or hawki benefits may be discontinued.

76.8(3) *Time frames for providing information or verification.* Clients have ten calendar days from the date on the written request by the department to provide additional information or verification requested. If the tenth calendar day falls on a weekend or state holiday, the individual will have until the end of business hours on the next business day to provide the information or verification. The information or verification is considered provided on the date it is received by the department.

76.8(4) *Extensions.* The applicant or member may request an extension for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification.

76.8(5) *Interviews.* Applicants and members who are being evaluated on the basis of the MAGI methodology will not be required to attend an interview. Applicants and members who are being evaluated on a basis other than the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the application process. If applicable, the department will notify the applicant, authorized representative, or responsible person of the date, time, and method of the interview. Notification will be provided personally by telephone, email, mail, or fax.

76.8(6) *Failure to comply.* An application will be denied or assistance will be discontinued if:

a. The applicant or member does not attend a required interview, pursuant to subrule 76.8(5), or

b. The department does not receive one of the following by the due date indicated on the written request for additional information in accordance with subrules 76.8(2) through 76.8(4):

(1) The information, verification, or a statement that reasonably explains the discrepancy;

(2) An authorization for the department to obtain the information or verification; or

(3) A request for an extension of the due date.

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) *Responsible person.* If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member.

a. Except as provided in paragraph 76.9(1)*"d,"* when the applicant or member is incompetent, incapacitated, or deceased, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare.

b. Except as provided in paragraph 76.9(1)*"d,"* when the applicant or member is unable to act on the applicant's or member's own behalf solely because the applicant or member is a minor, the responsible person shall be an adult in the child's household or family as described in paragraph 76.2(1)*"a."*

c. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative pursuant to subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

d. When there is no person as described in paragraphs 79.6(1)*"a"* through *"c"* to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes the required form, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

e. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

f. Copies of all correspondence the department would otherwise provide to the applicant or member will be provided to the recognized responsible person.

76.9(2) *Authorized representative.*

a. An individual or organization designated by a competent applicant or member, or by a responsible person recognized pursuant to subrule 76.9(1), or with other legal authority to do so may act on behalf of the applicant or member in the application process, in the review process, or for ongoing eligibility.

b. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant, member, or responsible person. The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's or member's behalf, complete and submit a review form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

c. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

d. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the department's website, mail, email, or fax or in person.

e. For purposes of this rule, the department will accept electronic, including telephonically recorded, signatures and handwritten signatures (including when transmitted by fax or other electronic means).

f. If the authorization:

(1) Indicates the time period or dates the authorization is to cover, the stated period or dates will be honored until or unless a rescission is submitted to the department as described in subparagraph 76.9(2)*"f"*(2) and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization.

(2) Does not indicate the time period or dates it is to cover, the authorization will be valid until the applicant, member, or responsible person modifies the authorization and notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the signature of the applicant, member, responsible person, or authorized representative, as appropriate.

g. Copies of all correspondence will be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

b. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible person must sign an agreement that the provider, staff member, or volunteer will adhere to the regulations in 42 CFR Part 431, Subpart F; 45 CFR §155.260(f) (relating to confidentiality of information); and 42 CFR §447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

c. The authorized representative or responsible person is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible person represents.

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of rule 441—75.8(249A).

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate whether notices and other communications are to be provided by the department in an electronic format through the individual's electronic account rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an email to the individual notifying the individual of the notice or other communication.

441—76.12(249A) Application not required.

76.12(1) *Adding a new person.*

a. Adding an eligible person. For members whose eligibility is based on the MAGI methodology, a new application is not required when an eligible person is added to an existing Medicaid household. Such a person is considered to be included in the application that established eligibility for the existing household. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date the person begins to live in the household or the date of report, whichever is later.

b. Adding a person previously ineligible due to a failure to cooperate. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing liability for support as described in 441—subrule 75.14(2) is to be granted Medicaid benefits, the earliest month for which that person may be eligible for coverage is the month that the person takes action(s) to meet the cooperation requirements described in 441—subrule 75.14(1) and as determined by child support services.

c. Adding a person previously ineligible due to failure to provide a social security number. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described in rule 441—75.9(249A) is to be granted Medicaid benefits, the person will be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

76.12(2) *Loss of hawki eligibility.* In those instances where a child loses hawki eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

76.12(3) *Grace period.*

a. At application. If benefits are denied for failure to provide requested information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department will complete the eligibility determination as though the information were timely received. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

b. At reinstatement after cancellation (including cancellation at the time of reenrollment). Eligibility for Medicaid may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

441—76.13(249A) Initial enrollment.

76.13(1) *Enrollment date.* The department will enroll applicants who have been determined to be eligible in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the month that the application was filed or the first day of the first month for which eligibility has been determined, whichever is later, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations pursuant to subrule 76.7(5).

(2) Eligibility under the qualified Medicare beneficiary coverage group described in 441—paragraph 75.6(5)*"a"* begins on the first day of the month after the month of decision.

(3) For individuals who are approved for Medicaid and who are eligible for SSI, programs related to SSI, or state supplementary assistance, Medicaid benefits will be effective on the first day of the month for which the individual meets all eligibility requirements, including resource eligibility, as of the first moment of the first day of the month.

(4) The enrollment date for retroactive Medicaid eligibility is determined pursuant to subrule 76.13(3).

b. Care or services prior to enrollment. No payment will be made for medical care or services received prior to the effective date of enrollment.

76.13(2) *Certification for services.* The department will issue a medical assistance eligibility card to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions.

a. Presumptive eligibility. A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action form that will include certification information.

b. Emergency Medicaid for noncitizens. An individual who is eligible only for limited emergency Medicaid for noncitizens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action that will include certification information.

76.13(3) *Retroactive enrollment.* Medical assistance will be available for all or any of the three months preceding the month in which an application is filed to persons who meet the requirements described within this subrule.

a. Except as provided in paragraph 76.13(3)*"e,"* retroactive medical assistance will be available for the months a person was pregnant, an infant (under the age of 1), a child under 19 years of age, or a resident of a nursing facility licensed under Iowa Code chapter 135C during any of the three months preceding the month in which an application is filed and who also meets the following conditions:

(1) Has medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if the application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance will be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(3)*"a"* are met.

d. Persons enrolled in Medicaid based on receipt of SSI benefits who wish to apply for Medicaid benefits for the three months preceding the month of application shall complete a form provided by the department.

e. Exceptions to retroactive enrollment. This subrule does not apply to the following persons who are otherwise eligible for retroactive enrollment:

(1) Persons whose citizenship status has not been verified even if they are eligible during a 90-day reasonable opportunity period.

(2) Persons determined eligible only under presumptive Medicaid benefits.

(3) Persons eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Persons eligible only under the home- and community-based waiver services program.

441—76.14(249A) Reenrollment. The department will review all conditions of eligibility for the purpose of determining continued enrollment in Medicaid pursuant to 441—Chapter 75.

76.14(1) *Reenrollment frequency.*

a. The department will conduct eligibility reviews for members whose eligibility is based on the MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided by rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

b. The department will conduct eligibility reviews for the following coverage groups as circumstances indicate but no more frequently than once every 12 months:

(1) Transitional Medicaid as described in 441—subrule 75.3(6).

(2) Medicaid for former foster care youth (EMIYA) as described in 441—subrule 75.3(12).

(3) Postpartum Medicaid as described in 441—subrule 75.3(4).

c. The department will conduct eligibility reviews for members whose eligibility is based on non-MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided in rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

76.14(2) *Reenrollment process.*

a. Reenrollment procedure. Reenrollment will be based on reliable information contained in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS. If the department is able to renew eligibility based on such information, the department must notify the individual of the eligibility determination and the basis of that determination. If any information in that notification form is inaccurate, the member must inform the department through any of the modes permitted for submission of an application under paragraph 76.2(1)*"b"* within 30 days.

b. Members whose eligibility for Medicaid is based on the MAGI methodology. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

c. Members whose eligibility for Medicaid is in non-MAGI related coverage groups. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

d. Failure to reenroll. Enrollment will end when information or documentation necessary to complete the determination of continued eligibility pursuant to subrules 76.8(2) through 76.8(4) is not returned before the end of the enrollment period. The department will notify the member of the disenrollment pursuant to 441—Chapter 16. Individuals whose eligibility ends must reapply unless the individual satisfies the requirements of subrule 76.12(3) or paragraph 76.14(2)*"e."*

e. Reconsideration period.

(1) For all coverage groups, except those specified in subparagraph 76.14(2)*"e"*(2), the department will reconsider the eligibility of an individual who is terminated for failure to submit the applicable review form as described in paragraph 76.14(2)*"b"* or *"c"* or for failure to provide necessary information in a timely manner and without requiring an application if the individual subsequently submits a review form within 90 days after the effective date of termination. The department will also reconsider eligibility as described in this subparagraph if the member provides an application form. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the review form. The eligibility effective date will go back to the first day of the first month of ineligibility only if all other eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility will not be granted any earlier than the month in which all eligibility criteria are met.

(2) For qualified Medicare beneficiaries (QMB), the provisions in subparagraph 76.14(2)*"e"*(1) apply, except that the review form as described at lettered paragraph 76.14(2)*"b"* or *"c"* will be acted

upon and treated like an application and the eligibility effective date will be determined pursuant to subparagraph 76.13(1)*"a"*(2).

f. Interview required. An individual whose eligibility is not based on the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the process.

441—76.15(249A) Report of changes. As a continuing condition of enrollment for Medicaid, applicants and current members shall report changes in circumstances as required in this rule.

76.15(1) A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the MAGI methodology, any change in the following must be reported:

(1) Income from all sources.
(2) Members of the household.
(3) School attendance.
(4) Mailing or living address.
(5) Receipt of a social security number.
(6) Health insurance premiums or coverage.
(7) Alien or citizenship status.
(8) Federal income tax filing status or claimed dependents for federal tax purposes.

b. In coverage groups for which Medicaid eligibility is not determined using the MAGI methodology, any change in the following must be reported.

EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

(1) Income from all sources.
(2) Resources.
(3) Members of the household.
(4) Recovery from disability.
(5) Mailing or living address.
(6) Health insurance premiums or coverage.
(7) Medicare premiums or coverage.
(8) Receipt of social security number.
(9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family, as those terms are defined in rule 441—75.1(249A).
(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation, or spenddown.
(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care, based on an adoption assistance agreement, or based on a guardianship assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, upon receipt of a social security number, and upon termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

(1) Income from all sources.
(2) Mailing or living address.
(3) Receipt of a social security number.

(4) Health insurance coverage.

(5) Alien or citizenship status.

76.15(2) Failure to report. When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible will be considered overpayments and subject to recovery from the member.

441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility will be evaluated and eligibility will be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrules 76.16(2) and 76.16(3) or as otherwise stated in 441—Chapter 75 or this chapter, action based on a change reported during a month will be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in rule 441—16.2(17A).

76.16(2) When a request is made to add a new person to the Medicaid household and that person meets the eligibility requirements, assistance will be acted upon pursuant to rule 441—76.12(249A).

76.16(3) When the reported change causes a change in coverage from a Medicare Savings Program coverage group described in 441—subrule 75.6(5) to coverage under Medicaid for employed people with disabilities (MEPD) as described in 441—subrule 75.6(6), the reported change will be effective the first day of the calendar month that the change was reported.

76.16(4) When the change creates ineligibility, eligibility under the current coverage group will be canceled and an automatic redetermination of eligibility will be completed in accordance with rule 441—76.17(249A).

441—76.17(249A) Timeliness requirements for conducting automatic redeterminations of eligibility. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, the department will automatically redetermine eligibility for other Medicaid coverage groups unless the reason for ineligibility is due to not meeting the requirements in rule 441—76.8(249A). If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility that applies to all coverage groups, no further redetermination will be required. When the redetermination is completed, the member will be notified of the decision in writing. The redetermination process will be completed as follows:

76.17(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department by the tenth of the month, the redetermination process will be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be the first day of the month following the month in which the information is received, pursuant to rule 441—76.16(249A).

76.17(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department after the tenth of the month, the redetermination process will be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be no earlier than the first day of the first month following the month in which the information is received, pursuant to rule 441—76.16(249A), but no later than the second month following the month in which the information is received.

76.17(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid members and the United States Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR §435.1003, the redetermination process will be completed within the extended time limit and the effective date of cancellation for the current coverage

group will be no later than the first day of the month following the month in which the extended time limit expires.

These rules are intended to implement Iowa Code chapter 249A.

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[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9703C

MEDICINE BOARD[653]

Adopted and Filed

Rulemaking related to physician supervision of a physician assistant

The Board of Medicine (Board) hereby rescinds Chapter 21, "Physician Supervision of a Physician Assistant," and adopts a new Chapter 21, "Physician Supervision of a Physician Assistant Pursuant to Iowa Code Chapter 148C," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A, 148, 148C and 272C.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 148C.3 and 272C.3.

Purpose and Summary

This rulemaking rescinds Chapter 21 and adopts a new chapter in lieu thereof. This rulemaking implements Iowa Code section 148C.5 as amended by 2023 Iowa Acts, House File 424, in accordance with the goals and directives of Executive Order 10. Iowa Code section 148C.3 requires the Board and Board of Physician Assistants to adopt joint rules requiring a licensed physician assistant to be supervised by a physician during the first two years of independent practice if the physician assistant has not previously practiced under a supervising physician or in collaboration therewith for a period of at least two years.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on May 28, 2025, as **ARC 9296C**. An Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on June 25, 2025, as **ARC 9379C**. A public hearing was held on the following date(s):

- July 15, 2025
- July 16, 2025

The legal representatives of the Iowa Physician Assistant Society attended a public hearing. Comments were received with overall support of this rulemaking and thanking the staff at the Board office for the support and work on this rulemaking. Comments were also received on subrules 21.1(3) and 21.5(2) requesting that the limit on a physician supervising only five physician assistants be removed since Iowa Code chapter 148C no longer contains the limitation. The Board has removed this limitation to be consistent with the statute. Comments were received with the recommendation to make it more explicit that the supervision is only of those physician assistants defined in Iowa Code chapter 148C who require supervision. The Board believes that it is adequately addressed in 481—Chapter 780,

which is referenced in these rules. The Board revised the title of this chapter to include "supervised pursuant to Iowa Code chapter 148C" to provide clarity.

Adoption of Rulemaking

This rulemaking was adopted by the Board on August 29, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any, pursuant to 481—Chapter 6.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 653—Chapter 21 and adopt the following **new** chapter in lieu thereof:

CHAPTER 21
PHYSICIAN SUPERVISION OF A PHYSICIAN ASSISTANT
PURSUANT TO IOWA CODE CHAPTER 148C

653—21.1(148,272C) Ineligibility determinants. A physician with an active permanent, special, or temporary Iowa license who is actively engaged in the practice of medicine in Iowa may supervise a physician assistant. A physician is ineligible to supervise a physician assistant for any of the following reasons:

21.1(1) The physician does not hold an active, permanent, special or temporary Iowa medical license.

21.1(2) The physician is subject to a disciplinary order of the board that restricts or rescinds the physician's authority to supervise a physician assistant. The physician may supervise a physician assistant to the extent that the order allows.

653—21.2(148,272C) Exemptions from this chapter. This chapter does not apply to the following:

21.2(1) A physician working in a federal facility or under federal authority when the provisions of this chapter conflict with federal regulations.

21.2(2) A physician who supervises a physician assistant providing medical care created by an emergency or a state or local disaster pursuant to Iowa Code section 148C.4.

653—21.3(148) Board notification. A physician who supervises a physician assistant shall notify the board of the supervisory relationship within 60 days of the provision of initial supervision and at the time of the physician's license renewal.

653—21.4(148,272C) Requirements for supervising. More information regarding requirements for supervising can be found in rules 481—780.6(148C) and 481—780.8(148C).

653—21.5(148,272C) Grounds for discipline. A physician may be subject to disciplinary action for supervising a physician assistant in violation of these rules, 481—Chapter 661, or 481—Chapter 780, which relate to duties and responsibilities for physician supervision of physician assistants. Grounds for discipline also include:

21.5(1) The physician supervises a physician assistant when the physician does not have sufficient training or experience to supervise a physician assistant in the area of medical practice in which a physician assistant is to be utilized.

21.5(2) The physician fails to ensure that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant.

21.5(3) The physician fails to adequately direct and supervise a physician assistant or fails to comply with the minimum standards of supervision in accordance with this chapter, 481—Chapters 780 through 784, and Iowa Code chapters 148 and 148C.

653—21.6(148,272C) Disciplinary sanction. The board may restrict or rescind a physician's authority to supervise a physician assistant as part of a disciplinary sanction following a contested case proceeding if the reason for the disciplinary action impacts the ability of the physician to supervise a physician assistant. The board shall notify the board of physician assistants when it takes a disciplinary action against a physician's license that affects the physician's authority to supervise a physician assistant.

653—21.7(148,272C) Communication with physician assistant supervisees. The physician shall notify all physician assistant supervisees within one workday upon receiving disciplinary action from the board or any other change in status that affects the physician's eligibility to supervise a physician assistant.

These rules are intended to implement Iowa Code chapter 148C and section 272C.3.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9704C

NATURAL RESOURCES DEPARTMENT[561]

Adopted and Filed

Rulemaking related to deer and turkey licenses

The Natural Resources Department (Department) hereby rescinds Chapter 12, "Special Nonresident Deer and Turkey Licenses," Iowa Administrative Code, and adopts a new Chapter 12 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 483A.24.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 483A.24.

Purpose and Summary

Chapter 12 implements Iowa Code section 483A.24, which requires the Director of the Department to provide a certain number of special nonresident turkey and deer licenses. These rules establish the process by which the Department will issue special nonresident deer and turkey licenses to individuals as part of statewide or local efforts to promote the State and its natural resources.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on January 8, 2025, as **ARC 8646C**. An Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on July 23, 2025, as **ARC 9426C**. A public hearing was held on the following date(s):

- August 12, 2025
- August 13, 2025

No one attended the public hearings. Written comments were received prior to the hearings opposing the broadening of the definition of "conservation organization." The Department recognizes this expansion will necessarily increase competition, but the successful recipients will have shown the greatest connection or alignment with, or most meaningful education outreach related to, natural resources and environmental conservation.

No changes from the Amended Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 21, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 561—Chapter 10.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 561—Chapter 12 and adopt the following **new** chapter in lieu thereof:

CHAPTER 12
SPECIAL NONRESIDENT DEER AND TURKEY LICENSES

561—12.1(483A) Purpose. These rules establish the process by which the department will issue special nonresident deer and turkey licenses to individuals as part of statewide or local efforts to promote the state and its natural resources.

561—12.2(483A) Definitions. When used in this chapter:

"Approved organization" means an organization that is incorporated under Iowa Code chapter 504 as a nonprofit organization, whose mission involves providing hunting experiences for disabled veterans and military personnel.

"Conservation organization" means an organization that is incorporated under Iowa Code chapter 504 as a nonprofit organization, whose mission emphasizes natural resource conservation or supports science-based natural resource management or who provides educational outreach efforts in Iowa related to environmental stewardship or natural resources conservation and management. A local or state chapter or division of a national or international conservation organization shall qualify as a conservation organization. A person who purchases a deer license from a conservation organization under these rules is not subject to the restriction provided in 12.5(1)*"b."*

"Coordinator" means the department staff person appointed by the director to administer the process for allocation of special nonresident deer and turkey licenses pursuant to this chapter.

"Department" means the department of natural resources.

"Director" means the director of the department of natural resources.

"Nonresident disabled veteran or disabled member of the armed forces" means a person who is a veteran and who has an assigned service-related disability rating of 30 percent or more by the United States Department of Veterans Affairs; or a person who is a member of the armed forces serving on active federal duty currently participating in the Integrated Disability Evaluation System (IDES).

"Outdoor industry" means a commercial enterprise or venture that promotes or otherwise contributes to the use of natural resources. A business that solely provides guide or outfitter services is not an outdoor industry.

"Program" means the review and selection process through which special nonresident deer and turkey licenses are allocated in accordance with Iowa Code section 483A.24 and these rules.

"Review committee" means the committee that ranks certain requests for special licenses for consideration by the director or the director's designee and consists of the following: the administrator of the conservation and recreation division, the chief of the wildlife bureau, the chief of the law enforcement bureau, the chair of the natural resource commission, and the vice-chair of the natural resource commission.

"Special licenses" means the special nonresident deer licenses and special nonresident turkey licenses issued pursuant to these rules.

"Special nonresident deer license" means a deer license issued pursuant to Iowa Code section 483A.24(3).

"Special nonresident turkey license" means a turkey license issued pursuant to Iowa Code section 483A.24(4).

"Sponsor" means an entity that applies on behalf of one or more hunters. Sponsors shall either conduct business in Iowa and be registered with the secretary of state or have some other affiliation with the state of Iowa.

"Statewide signature event organization" means an authority of the state with a foundation dedicated to a mission of making capital improvements on state property or that serves as a major platform for the promotion of Iowa's agriculture, culture, and natural resources.

561—12.3(483A) Availability of special licenses.

12.3(1) The program shall be available to provide no more than the number of special licenses allowed by Iowa Code section 483A.24 to nonresidents through requests submitted by individual hunters, through a sponsor, or through an approved organization.

12.3(2) A statewide signature event organization shall receive one special nonresident deer license upon application. The statewide signature event organization shall return to the department the greater

amount of either one-half of the proceeds from its sale of the special nonresident deer license or the fee for a nonresident deer license as set forth in Iowa Code section 483A.1. The department's proceeds shall cover the cost of the special nonresident deer license. A license made available to a statewide signature event organization in accordance with this subrule may be valid for up to two years after selection of the organization by the director or the director's designee. The statewide signature event organization shall notify the coordinator immediately following the sale of the special nonresident deer license of which year and for what season the special nonresident deer license will be used.

561—12.4(483A) Coordinator duties. The coordinator of the program shall:

12.4(1) Assist the review committee in the evaluation and selection of hunters who may receive special licenses.

12.4(2) Develop templates for requests for special licenses and provide the templates to hunters, sponsors, and approved organizations upon request.

12.4(3) Convene the review committee to rank hunters according to the criteria in 561—12.7(483A).

12.4(4) Summarize each request received and distribute the summaries to the review committee and the director or the director's designee.

12.4(5) Establish the date on which applications for special licenses for disabled veterans and disabled active military personnel are due, establish the dates on which the director or the director's designee will select the conservation organizations and hunters who will receive special licenses, and inform the conservation organizations, the approved organizations and the hunters of their selection.

561—12.5(483A) Request, review, and selection process for promotional special licenses.

12.5(1) *Submission of requests.*

a. Individual hunters or sponsors shall submit a request, or requests, to the coordinator.

b. Applicants will not qualify for a deer license under this rule if they were issued a deer license under this rule the previous year.

c. Hunters awarded a deer license under this rule may purchase preference points for the regular nonresident deer license and shall not lose those preference points when awarded a deer license under this rule.

12.5(2) *Review.* The review committee shall review the summaries prepared by the coordinator, rank the hunters according to criteria in 561—12.7(483A), and forward the rankings to the director or the director's designee for consideration and final selection. The review committee shall exercise its discretion and, in addition to the criteria in 561—12.7(483A), shall also consider the following:

a. Requests that demonstrate little or no promotion of the state of Iowa or its natural resources shall not be included in the rankings forwarded to or considered by the director or the director's designee.

b. Requests from a sponsor, a sponsor-related entity, or hunter that has been found guilty of a game violation in Iowa or elsewhere within the past five years or that, in the opinion of the review committee, has exhibited poor hunting ethics or judgment shall not be considered for a special license.

c. Review of requests shall occur at least once annually but may occur more frequently as needed based upon the number of requests and the dates by which they are received.

12.5(3) *Selection and payment.* Upon notice of selection to receive a special license, the sponsor or hunter shall make payment in accordance with 561—12.12(483A) to the department through the coordinator.

561—12.6(483A) Consideration of requests for promotional special licenses. The review committee will recommend to the director or the director's designee which conservation organizations are best qualified to promote the state and its natural resources. In making recommendations to the director or the director's designee, the review committee will base its recommendations on the expected ability of hunters to promote the state and its natural resources and, if applicable, based on the degree of success special license holders have had in previous years or seasons in promoting the state and its natural resources. By way of illustration, the committee may consider requests from the following:

12.6(1) A hunter who has a direct beneficial impact on the state through an arm's-length business relationship with an Iowa-based outdoor industry.

12.6(2) A conservation organization that will use the special nonresident deer license as a fundraiser for that organization. A conservation organization shall be limited to one special nonresident deer license per year, whether the organization is a local or state chapter or division of a national or international conservation organization. The organization shall return to the department the greater amount of either one-half of the proceeds from its sale of the special nonresident deer license or the fee for a nonresident deer license as set forth in Iowa Code section 483A.1. The department's proceeds shall cover the cost of the special nonresident deer license. A license made available to a conservation organization in accordance with this subrule may be valid for up to two years after selection of the organization by the director or the director's designee. The sponsoring conservation organization shall notify the coordinator immediately following the sale of the special nonresident deer license of which year and for what season the special nonresident deer license will be used. The conservation organization shall specifically explain how and during what period the organization will market the special nonresident deer license for auction or some other legal fundraiser.

12.6(3) A hunter nominated by the governor or a member of the Iowa legislature.

12.6(4) A hunter recommended by the department.

12.6(5) A hunter who is a well-known public figure nationally or regionally and who may provide a positive portrayal of the state and its natural resources.

561—12.7(483A) Ranking criteria for promotional special licenses.

12.7(1) The following criteria shall be used by the review committee to rank individual hunters as identified in 12.6(1), 12.6(4) and 12.6(5). The rankings shall be determined as the average of the following rating points and will be provided to the director or the director's designee as an aid in determining the selection of hunters.

a. Five points if the hunter is directly affiliated with an Iowa-based outdoor industry.

b. From 0 to 10 points for the following:

(1) The relative size of the hunter's potential audience.

(2) The hunter's proposal to promote the state and its natural resources.

(3) If the hunter has received a special license in the past, the value of the actual promotion of the state and its natural resources or special services provided as a result.

c. From 0 to 5 points if the hunter meets the description in 12.6(5).

12.7(2) A conservation organization's request shall be forwarded to the director or the director's designee if the conservation organization meets the definition in 561—12.2(483A) and approval shall be based on evaluation of the organization's prior performance, if any, in selling the special nonresident deer license.

12.7(3) Hunters as identified in 12.6(3) shall not be ranked by the review committee, and their requests will be forwarded to the director or the director's designee for consideration.

561—12.8(483A) License term for promotional special licenses. With the exception of the term provided for in 12.6(2), special licenses issued under these rules shall be valid for only the applicable deer or turkey season immediately following allocation of the license.

561—12.9(483A) Reporting by recipients of promotional special licenses. Within eight months after a hunter's participation in a hunt with a license issued pursuant to this chapter, the sponsor or hunter shall provide to the coordinator information about the hunt to demonstrate how the hunt will provide or has provided promotion of the state and its natural resources. The director or the director's designee may consider compliance with this reporting requirement in evaluating future requests.

561—12.10(483A) License costs for promotional special licenses. With the exception provided in 12.6(2) for conservation organizations, a nonresident who obtains a special license issued pursuant to this chapter shall pay the applicable fee as follows:

12.10(1) For a special nonresident deer license, the fee described in Iowa Code section 483A.1 for a deer hunting license, antlered or any sex deer.

12.10(2) For a special nonresident turkey license, the fee described in Iowa Code section 483A.1 for a wild turkey hunting license.

561—12.11(483A) Request, review, and selection processes for special licenses for nonresident disabled veterans or disabled members of the armed forces.

12.11(1) *Submission of requests.*

a. Individual hunters or approved organizations shall submit a request, or requests, to the coordinator.

b. Applicants will not qualify for a deer or turkey license under this rule if they were issued a deer or turkey license under this rule the previous year. However, if there are unclaimed deer or turkey licenses under this rule, then the coordinator may keep a list of applicants who received licenses the previous year and who apply for the current year, and process those applicants' applications to determine the recipients of the unclaimed licenses.

c. Hunters awarded a deer license under this rule may purchase preference points for the regular nonresident deer license and shall not lose those preference points when awarded a deer license under this rule.

12.11(2) *Review.* After the established deadlines have passed, the coordinator shall review the applications for completeness and shall process the complete applications to determine the recipients of the special licenses. The coordinator shall exercise discretion and shall also consider the following:

a. Requests from an approved organization or hunter that has been found guilty of a game violation in Iowa or elsewhere shall not be considered for a special license.

b. If special licenses are unclaimed after the established deadlines, the coordinator may set new deadlines and inform participating approved organizations that licenses are still available.

12.11(3) *Selection and payment.* Upon notice of selection to receive a special license, the approved organization or hunter shall make payment in accordance with 561—12.17(483A) to the department through the coordinator.

561—12.12(483A) License term for disabled veteran and military special licenses. Special deer or turkey licenses issued under these rules shall be valid for only the applicable deer or turkey season immediately following allocation of the license.

561—12.13(483A) License costs for disabled veteran and military special licenses. A nonresident who obtains a special license issued pursuant to this chapter shall pay the applicable fee as follows:

12.13(1) For a special nonresident deer hunting antlered or any sex deer license or a turkey hunting license, the fee described in Iowa Code section 483A.24(5)*"c."*

12.13(2) For a special nonresident hunting license that includes the wildlife habitat fee, the fee described in Iowa Code section 483A.24(5)*"d."*

These rules are intended to implement Iowa Code section 483A.24.

[Filed 10/21/25, effective 12/17/25]
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ARC 9705C

PUBLIC HEALTH DEPARTMENT[641]

Adopted and Filed

Rulemaking related to brain injury services program

The Department of Health and Human Services hereby rescinds Chapter 56, "Brain Injury Services Program," Iowa Administrative Code, and adopts a new Chapter 56 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 135.22B.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 135.22B.

Purpose and Summary

The purpose of the Brain Injury Services Program is to provide services, service funding, or other support for persons with a brain injury under one of the program components established pursuant to Iowa Code section 135.22B. The overall purpose of this chapter is to establish administrative rules in accordance with Iowa Code section 135.22B relative to the financial eligibility requirements for services under the waiver-eligible and cost-share components of the Brain Injury Services Program.

While the services described in this chapter are not funded, the resource facilitation and training components of the program, which are not the subject of this chapter, have been continuously funded since 2006.

The chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result, the Department updated definitions to refer to the appropriate Iowa Code section; eliminated redundant, outdated, and restrictive language; and added dates certain.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025, as **ARC 9527C**. Public hearings were held on the following date:

- September 23, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 16, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on January 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 641—Chapter 56 and adopt the following **new** chapter in lieu thereof:

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

641—56.1(135) Definitions. For purposes of this chapter, the following definitions apply:

"Assessment" means the review of the member's current functioning with regard to the member's situation, needs, strengths, abilities, desires and goals.

"Brain injury services waiver" means the same as defined in Iowa Code section 135.22B.

"Cost share" means the portion an individual is responsible to pay for services received by the individual.

"Countable income," when determining initial and ongoing eligibility for the brain injury services program, means all earned and unearned income unless specifically exempted in 441—subrule 86.2(2).

"Family size," for purposes of establishing initial and ongoing eligibility under the brain injury services program, means all persons living together who are children and who are parents of those children as defined in 441—subrule 86.2(3).

"Member" means an individual who has applied for and been found eligible to participate in the waiver-eligible component or the cost-share component of the brain injury services program.

"Program" means the department's brain injury services program.

641—56.2(135) Waiver-eligible component. Persons eligible for the brain injury services waiver and on the waiting list for the waiver are eligible for the waiver-eligible component. The program may provide funding for the nonfederal share of the cost of services if the appropriation for the medical assistance program does not have sufficient funding designated to do so.

56.2(1) Provision of funding under this component is not an entitlement and is subject to funding availability.

56.2(2) A person who receives support under the waiver-eligible component of the program is not eligible to receive support under the cost-share component of the program.

641—56.3(135) Cost-share component. Persons determined ineligible for the brain injury services waiver due to fiscal or functional criteria or persons who are eligible for the waiver but for whom funding was not authorized or available to provide waiver eligibility are eligible for the cost-share component of the program.

56.3(1) An individual must meet all of the following requirements:

a. The individual is aged one month through 64 years.

b. The individual has a brain injury as defined in Iowa Code section 135.22.

c. The individual is a resident of Iowa and either a United States citizen or a qualified alien as defined in 8 U.S.C. Section 1641 as amended to August 1, 2025.

d. The individual meets the cost-share component's financial eligibility requirements and is willing to pay a cost share for the cost-share component.

56.3(2) Financial eligibility and cost share. The department will use countable income to determine initial and ongoing eligibility for the program. Cost share will be as follows:

a. Individuals who are at 300 percent or below the federal poverty level for a family of the same size will not be assessed a cost share.

b. Individuals whose countable income is between 301 percent and 350 percent of the federal poverty level for a family of the same size will be assessed a 10 percent cost share for services that will be payable to the service provider.

c. Individuals whose countable income is between 351 percent and 400 percent of the federal poverty level for a family of the same size will be assessed a 20 percent cost share for services that will be payable to the service provider.

d. Individuals whose countable income is above 400 percent of the federal poverty level for a family of the same size will be assessed a 30 percent cost share for services that will be payable to the service provider.

56.3(3) The cost-share component must be the source of last resort for payment; the program will not pay for services when the provision of those services is mandated by law or administrative rule to be the responsibility of another governmental unit, private agency or program. Brain injury cost-share services are not available to an individual who receives services or funding under any type of medical assistance home- and community-based services waiver.

641—56.4(135) Application process.

56.4(1) The department will provide the application materials, including the waiver application and any denial letter, financial assessment, and functional assessment regarding the person in an agreed-upon format.

56.4(2) The department will determine eligibility within 45 days of receipt of complete application materials.

a. After determining if the applicant's service needs fit within the scope of the program, the department will inform the discharge planner or case manager on behalf of the applicant or the applicant's legal representative of the applicant's eligibility.

b. The case manager will establish an interdisciplinary team for each member and, with the team, identify the member's plan based on the member's needs and desires as well as the availability and appropriateness of services. The case manager will notify the department of the service plan.

c. The date of eligibility for applicants deemed eligible for the cost-share component will be the date when both the service eligibility and financial eligibility assessments have been completed.

d. The department will notify the applicant or the applicant's legal representative within seven days of the date eligibility determination is completed.

56.4(3) After determining an applicant's eligibility, if no payment slot is available, the program will enter the applicant on a waiting list according to the following:

a. The date a completed application is date-stamped in a county office of the department. If more than one application is received on the same date, applicants will be entered on the waiting list on the basis of the applicant's month of birth, with January designated as month one.

b. As slots become available, applicants will be selected from the waiting list based on their order on the waiting list to maintain the number of persons approved for participation in the program.

56.4(4) The member or the member's legal representative shall complete and sign a Brain Injury Functional Assessment form indicating the member's choice of caregiver.

56.4(5) The member's case manager will initiate development of the consumer's service plan and commencement of services. All service plans must be approved by the program.

56.4(6) The department will not pay the cost of services provided to a member prior to approval of eligibility.

56.4(7) The program will make the final determination as to whether program funding will be authorized under the cost-share component.

641—56.5(135) Service providers and reimbursement.

56.5(1) A service provider must either be certified to provide services under the brain injury services waiver or have a contract with a county to provide services and apply to become certified to provide services under the brain injury services waiver within 90 days of the date that services commence.

56.5(2) The reimbursement rate payable for the cost of a service provided under the cost-share component is the rate payable under the medical assistance program. However, if the service provider

does not have a medical assistance program reimbursement rate, the rate will be the amount payable under the county contract.

56.5(3) All service providers must contract with the department and will be paid retroactively to the date of service eligibility.

56.5(4) Service providers will be responsible for billing and collection of any cost share from an individual as determined by the department.

641—56.6(135) Available services/service plan.

56.6(1) Services available will be consistent with the services offered through the Medicaid home- and community-based services waiver.

56.6(2) Service plans must reflect use of all services, including non-cost-shared services, to ensure that no duplication of services occurs.

56.6(3) All service plans must be submitted, either electronically or in hard-copy format, to the program for approval prior to implementation.

56.6(4) Any change to the service plan must be approved by the program.

641—56.7(135) Redetermination.

56.7(1) The department will annually conduct a complete financial redetermination of continuing eligibility for the program after consultation with the case manager and the interdisciplinary team.

56.7(2) The department will also conduct a redetermination of continuing eligibility when a change in financial or functional circumstances occurs that affects eligibility.

641—56.8(135) Appeal rights. Any individual denied funding under either the waiver-eligible or the cost-share component of the program may appeal pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code section 135.22B.

[Filed 10/16/25, effective 1/1/26]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9706C

PUBLIC HEALTH DEPARTMENT[641]

Adopted and Filed

Rulemaking related to tobacco use prevention and control community partnership initiative

The Department of Health and Human Services hereby rescinds Chapter 151, "Tobacco Use Prevention and Control Community Partnership Initiative," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapter 142A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2024 Iowa Acts, House File 2673, and Executive Order 10.

Purpose and Summary

This rulemaking was undertaken as a result of Executive Order 10. This chapter became obsolete effective July 1, 2025, due to the enactment of 2024 Iowa Acts, House File 2673. That legislation, in part, realigned the State's behavioral health service system and repealed Iowa Code chapter 142A, which established the Tobacco Use Prevention and Control Commission (Commission). The Commission was

dissolved effective July 1, 2025. Because the Commission was dissolved, this chapter is no longer needed.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025, as **ARC 9526C**. Public hearings were held on the following date:

- September 23, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 16, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on January 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **641—Chapter 151**.

[Filed 10/16/25, effective 1/1/26]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9707C

REVENUE DEPARTMENT[701]

Adopted and Filed

Rulemaking related to contested cases related to alcohol and lottery proceedings and tax appeals, taxpayer representation, and other administrative procedures

The Revenue Department hereby amends Chapter 6, "Contested Cases Related to Alcohol and Lottery Proceedings," and Chapter 7, "Tax Appeals, Taxpayer Representation, and Other Administrative Procedures," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 99G.9, 123.10 and 421.17.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

Purpose and Summary

The purpose of this rulemaking is to provide updated rules on Department processes regarding contested case procedures for modernized electronic filing capabilities. Once the Department has undergone completion of its Modernization Project, Iowans will be able to utilize GovConnectIowa for appeals, petitions for declaratory order, petitions for rulemaking, and petitions for rule waiver for all matters before the Department.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9573C**. A public hearing was held on the following date(s):

- October 7, 2025

No one attended the public hearing. No public comments were received. One change from the Notice has been made in paragraph 7.3(1)"a" to remove the date of November 12, 2024, due to the Department deeming it no longer relevant.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 701—3.7(99G,123,421,17A).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Amend rule 701—6.4(99G,123,17A) as follows:

701—6.4(99G,123,17A) Requests for a contested case proceeding.

6.4(1) Any person claiming an entitlement to a contested case proceeding shall file a written request within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the agency action in question.

6.4(2) The request for a contested case proceeding should state the name and address of the requester, identify the specific agency action that is disputed and, where the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved, and include a short and plain statement of the issues of material fact in dispute.

6.4(3) A person may submit a request for a contested case proceeding using one of the methods described in 701—subrule 7.3(1).

ITEM 2. Amend rule 701—7.3(17A) as follows:

701—7.3(17A,99G,123,421-454) How to submit an appeal, petition or related documents; service. Appeals, petitions, and other documents governed by this chapter may be filed electronically, by mail, or in person, in accordance with the limits described below. The headquarters of the department in the Hoover State Office Building in Des Moines, Iowa, will generally be open between the hours of 8 a.m. and 4:30 p.m. daily, except Saturdays, Sundays, and holidays as defined in Iowa Code section 421.9A.

7.3(1) *Ways to submit an appeal, petition, or related document.* Unless otherwise specified in another rule in this chapter, a person may submit an appeal, petition, related document, or document filed during an appeal or pending petition:

a. By submitting through GovConnectIowa. ~~As of November 12, 2024,~~ GovConnectIowa is available for filing appeals, petitions for declaratory order, petitions for rulemaking, and petitions for rule waiver for all ~~tax types as well as for lottery and alcohol matters but is only available for filing appeals for the following tax types: sales, use, E911, withholding, motor vehicle fee for new registration, vehicle lease, cigarette, tobacco products, alternative nicotine, vapor device, vapor products, drug stamp, utility replacement, central assessments, statewide property, motor fuel, hotel/motel, local option sales, automobile rental, water service excise, individual income, fiduciary income, corporation income, S corporation income, partnership income, composite, franchise, inheritance, moneys and credits, and tax credits and distributions associated with these tax types~~ matters before the department.

b. By email to idrhearings@iowa.gov.

c. By mail to Legal Services and Appeals Division, Iowa Department of Revenue, P.O. Box 14457, Des Moines, Iowa 50306-3457.

d. By hand delivery to the department's customer service desk in the Hoover State Office Building, First Floor, 1305 East Walnut Street, Des Moines, Iowa 50319, during regular business hours.

7.3(2) and **7.3(3)** No change.

This rule is intended to implement Iowa Code chapter 17A.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9710C

REVENUE DEPARTMENT[701]

Adopted and Filed

Rulemaking related to device excise tax

The Revenue Department hereby adopts new Chapter 235, "Device Excise Tax," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 423.25, 453E.2 and 453E.5(5).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 17A and 453E.

Purpose and Summary

The purpose of the rulemaking is to adopt new Chapter 235. This chapter describes the Department's interpretation of Iowa Code chapter 453E as it applies to the regulation and taxation of devices.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9570C**. A public hearing was held on the following date(s):

- October 7, 2025

No one attended the public hearing. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 701—3.7(99G,123,421,17A).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 701—Chapter 235:

CHAPTER 235
DEVICE EXCISE TAX

701—235.1(453E) Purpose; definitions.

235.1(1) *Purpose.* This chapter sets forth the department of revenue's rules on the administration and regulation of the sale of devices and the imposition, collection, and remittance of excise tax on those devices.

235.1(2) *Definitions.* Unless otherwise indicated in the rule or required by context, all terms and phrases have the same meaning as defined in Iowa Code chapter 453A and section 453E.1. For purposes of this chapter, the following definitions also apply:

"Combustion" means to burn or to heat to the point of creating an aerosol, either directly or indirectly.

"Designed for use" means the primary intended purpose of the object and may be measured at the time of manufacture, distribution, or point of sale.

"GovConnectIowa" means the e-services portal of the department of revenue.

"Inhalation" means to take an aerosol into the body via the nose or mouth, even if the aerosol does not reach or is not absorbed through the lungs.

This rule is intended to implement Iowa Code chapter 453E.

701—235.2(453E) Devices.

235.2(1) *Device.* "Device" is defined in Iowa Code section 453E.1 and provides the factors the department will consider when determining whether a particular product is subject to regulation under Iowa Code chapter 453E and these rules.

235.2(2) *Examples.*

EXAMPLE 1: Retailer A holds a retail tobacco permit. Retailer A sells an object made from glass. The object has a bowl, a water reservoir, a tube, and a mouthpiece. The accompanying instructions direct users to place tobacco in the bowl, heat the bowl, and inhale the resulting aerosol. Because the object is made entirely of glass and is designed for use in inhaling through combustion tobacco, the object is a device.

EXAMPLE 2: Retailer B holds a retail tobacco permit. Retailer B sells an object identical to Example 1, except the object has no instructions and Retailer B describes it as a "sculpture." Retailer B also displays a sign next to the object that says, "DECORATION ONLY. DO NOT USE WITH TOBACCO." Despite the signage and lack of instructions, the object is a device; Retailer B is a supplier of tobacco products, and the object is designed for use as a device.

EXAMPLE 3: Retailer C holds a retail tobacco permit. Retailer C sells an object described as a "hookah." The object has a metal bowl to fill with water, a metal pipe, tubing, and a mouthpiece. The object's accompanying instructions direct users to place lit coals next to shisha (flavored tobacco) in order to heat the shisha without burning the shisha. By heating the shisha, the hookah creates an aerosol. Users can then inhale the aerosol from the shisha. Because the shisha is intended to be inhaled through combustion in the object, the object is a device.

EXAMPLE 4: Retailer D holds a retail tobacco permit. Retailer D sells a small silk flower packaged within a four-inch-long glass tube. Purchasers commonly dispose of the silk flower and use the tube for inhaling through combustion tobacco, hemp, other plant materials, or a controlled substance. Therefore the glass tube is a device. The sale is subject to regulation under Iowa Code chapter 453E, and the device excise tax applies to the entire sales price.

EXAMPLE 5: Retailer E does not hold a retail tobacco permit. Retailer E primarily sells scientific supplies and equipment, including a 100-millimeter-long glass test tube. The test tube's instructions only concern its scientific use. The descriptive materials accompanying the test tube only depict its scientific use. The test tube's advertising only concerns its scientific use. Retailer E only displays the test tube in a scientific manner. Retailer E otherwise is not a supplier of devices or related items. The test tube is commonly used for legitimate scientific purposes in the scientific community. While some individuals outside of the scientific community may be able to use this test tube as a means for drug consumption, the product is designed for use in scientific applications. The test tube is not a device.

This rule is intended to implement Iowa Code chapter 453E.

701—235.3(453E) Permit applications, approvals, and denials.

235.3(1) *Applications for permits in general.* The application forms for all permits issued under Iowa Code chapter 453E are available from the department. Permit application forms are to be submitted in accordance with paragraph 235.3(1)*"b."*

a. Each permit application, whether for a device retailer or a device delivery seller, must include but is not limited to the following information:

(1) Nature of the applicant's business;

(2) Type of permit requested;

(3) Address of the principal office of the applicant;

(4) Address of the place of business for which the permit is to apply;

(5) Names and addresses of no more than three principal officers, partners, or members if the business is not a sole proprietorship;

(6) Other permits issued under Iowa Code chapter 453A;

(7) Sales and use tax permit number issued under Iowa Code chapter 423;

(8) Signature of the person authorized to complete the application. For applications submitted under Iowa Code chapter 453E and these rules, the applicant's email address included on the electronic application constitutes a valid signature; and

(9) Any other information required on the forms issued by the department for the purpose of administering Iowa Code chapters 453A and 453E and these rules.

b. Electronic submission.

(1) Applicants seeking a device retailer or device delivery sale permit must submit their applications via GovConnectIowa.

(2) Applicants seeking a device retailer or device delivery sale permit must hold a valid, unsuspended or unrevoked retail tobacco permit, pursuant to Iowa Code section 453A.47A, or apply for a retail tobacco permit at the same time of their applications for a device retailer or device delivery sale permit.

(3) Applicants seeking a device retailer or device delivery sale permit must hold a valid, unsuspended or unrevoked sales and use tax permit, pursuant to Iowa Code chapter 423, or apply for a sales and use tax permit at the same time of their applications for a device retailer or device delivery sale permit.

(4) For device retailers and delivery device sellers, the legal name of the applicant must be the same as on the sales and use tax and retail tobacco permits or permit applications.

235.3(2) *Approval of permit application.*

a. Device retailer permit applications.

(1) The power to grant the device retailer permit is within the authority of the city council or board of supervisors of the jurisdiction in which the business is located. Uniform, nondiscriminatory limits may be placed by the city council or board of supervisors on the issuance of device retailer permits within the respective jurisdiction.

(2) Applying for a permit does not equal approval, so devices cannot be sold during the pendency of the retail application before the local jurisdiction.

b. Device delivery sale permit applications.

(1) The power to grant or deny the device delivery sale permit is within the authority of the department.

(2) The department will not approve a device delivery sale permit until or unless all requisite permits under Iowa Code section 453E.3(1) have been approved by the applicable local jurisdiction and the associated application fee has been submitted to the department.

c. Issuance of device retailer and device delivery sale permits.

(1) Regardless of the entity or jurisdiction that approves device retailer or device delivery sale permit applications under this rule, the department will issue the permit to the device retailer or device delivery seller.

(2) Submission of an application by the business or approval of an application by the state or locality is not sufficient to make device retail or delivery sales of devices. Device retailers and device delivery sellers must have been issued a permit by the department before making retail or delivery sales of devices.

235.3(3) *Denial of device retailer and device delivery sale permit applications.* Rule 701—201.10(423) characterizes the term "substantially delinquent" in paying a tax.

a. The department may deny a permit to any applicant who is, at the time of application, substantially delinquent in paying any tax due that is administered by the department or the interest or penalty on the tax.

b. If the applicant is a partnership, the department may deny the applicant a permit if a partner is substantially delinquent in paying any tax, penalty, or interest regardless of whether the tax is in any way a liability of or associated with the partnership.

c. If an applicant for a permit is a corporation, the department may deny the applicant a permit if any officer, with a substantial legal or equitable interest in the ownership of the corporation, owes any delinquent tax, penalty, or interest of the applicant corporation. Unlike a partnership, the corporation must initially owe the delinquent tax, penalty, or interest and the officer must be personally and secondarily liable for the tax.

d. The director will deny a permit to any applicant who is an individual if the department has received a certificate of noncompliance from child support services in regard to the individual unless the unit furnishes the department with a withdrawal of the certificate of noncompliance.

e. The department will not refund permit application fees if the application is denied by the local jurisdiction or the department or if the permit is suspended or revoked.

235.3(4) *Device retailer and device delivery sale permits.*

a. Device retailer permits.

(1) Location. A device retailer permit only authorizes retail sales of devices at the location described in the permit. A device retailer must obtain a separate permit for each place of business owned or operated by the retailer from which retail sales of devices will be made.

(2) Display.

1. Device retailer permits must, at all times, be publicly displayed by the device retailer at the business location named in the permit. "Publicly displayed" means that the permit is easily seen by the public and persons authorized to inspect the business.

2. When requested by any agent of the department or any peace officer, the business proprietor or keeper of the building in which the devices are kept for retail sale, or with the intent to sell at retail, must produce the device retailer permit.

3. Refusal or failure to exhibit the device permit is prima facie evidence that devices are being kept for sale or with the intent to sell the devices in violation of Iowa Code chapter 453E.

b. Device delivery sale permits.

(1) Location. A device delivery sale permit only authorizes delivery sales of devices from the location described in the permit. A device delivery seller must obtain a separate permit for each place of business owned or operated by the delivery seller from which delivery sales of devices will be made.

(2) Display.

1. When requested by any agent of the department or any peace officer, the business proprietor or keeper of the building in which the devices are kept for sale by delivery, or with the intent to sell by delivery, must produce the device delivery sale permit.

2. Refusal or failure to exhibit the device permit is prima facie evidence that devices are being kept for sale or with the intent to sell the devices in violation of Iowa Code chapter 453E.

c. Applicable dates. Approved device retailer and device delivery sale permits will provide the dates during which devices may be sold pursuant to that permit. Retail and delivery sales of devices made before this approval period are unlawful unless authorized under another permit.

(1) The date included on a device retailer or device delivery sale permit application and the date when an application was submitted are not the relevant dates to determine whether a sale is unauthorized under Iowa Code section 453E.3.

(2) Local jurisdictions and the department shall not backdate approved device retailer or device delivery sale permits to coincide with an application or submission date.

235.3(5) *Change of location, ownership, or legal or operating name of a business.*

a. Change of location.

(1) If the holder of a device retailer permit or a device delivery sale permit changes the location of a business requiring a device permit, the existing permit is not valid for the new location.

(2) Change of location within the same jurisdiction. If a permittee changes the location of a retail operation requiring a device retailer permit but remains within the same jurisdiction that granted the original permit, the permittee may exchange the invalid permit (valid only for the location described in the original permit) for a valid permit free of charge and without submitting an additional device retailer permit application.

(3) Change of location to another jurisdiction. If a permittee changes the location of a retail operation requiring a device retailer permit to a location outside of the original jurisdiction that approved the original permit, the permittee must surrender the invalid permit to the original jurisdiction, apply for a new permit in the new jurisdiction, and pay the requisite permit fees.

(4) Examples.

EXAMPLE 1: Tobacco Store sells tobacco products and devices at retail and has obtained the requisite retail permits from the city of Des Moines. The establishment moved to a new location that is one block away but still within the city limits of Des Moines. Tobacco Store's retail permits are valid only for the location described in the permit. Therefore, the original permits are no longer valid. However, since the establishment remains within the jurisdiction that granted the original permits (Des Moines), Tobacco Store can exchange the original, presently invalid permits for valid permits with a new location description without submitting a new application or paying additional fees.

EXAMPLE 2: Same as Example 1, except the new location of Tobacco Store is outside the corporate limits of Des Moines and within an unincorporated area of Polk County. Tobacco Store must surrender the invalid permits to the city of Des Moines, apply for and obtain new retail permits from Polk County, and pay all the requisite permit fees.

b. Changes of ownership, business structure, and business name.

(1) If a place of business with a device retailer or device delivery sale permit changes ownership or legal structure, the old permits cannot be assigned or transferred to the new owners and must be surrendered.

(2) The new owners must submit new permit applications, including paying the requisite permit fees.

c. Change of legal or operating name of a business. If a place of business with a device retailer or device delivery sale permit changes the legal or operating name of the business, the permittee must surrender the invalid permit to the original jurisdiction, apply for a new permit in the new jurisdiction, and pay the requisite permit fees.

This rule is intended to implement Iowa Code sections 453E.3 and 453E.4.

701—235.4(453E) Permit cancellation, suspension, and revocation.

235.4(1) *No proration or refund of permit fees.* Permit fees for device retailer and device delivery sale permits are not subject to proration or refund in the event the permit is canceled, suspended, or revoked.

235.4(2) *Administrative procedure for permit suspensions and revocations.* Any permit suspension or revocation by the department under Iowa Code chapter 453E and this rule is subject to the requirements of "contested case procedures" and "license and permit denials and revocations" contained in 701—Chapter 7.

235.4(3) *Notice and hearing.* The department may revoke or suspend a retail device or device delivery sale permit pursuant to Iowa Code section 453E.7 after giving the permit holder notice and an opportunity to be heard.

235.4(4) *Delinquency of tax, penalty, or interest.* Rule 701—201.10(423) provides information on the term "substantially delinquent" in paying a tax.

a. The department may revoke the permit of any permit holder who becomes substantially delinquent in paying any tax that is administered by the department or the interest or penalty on the tax.

b. If the permit holder is a corporation, the department may revoke the permit if any officer with a substantial legal or equitable interest in the ownership of the corporation owes any delinquent tax, penalty, or interest of the applicant corporation. In this latter instance, the corporation must initially owe the delinquent tax, penalty, or interest and the officer must be personally and secondarily liable for the tax.

c. If the permit holder is a partnership, a permit cannot be revoked for a partner's substantial delinquency in paying any tax, penalty, or interest that is not a liability of the partnership.

235.4(5) *Revocation by a local jurisdiction.*

a. Any permit revocation by a board of supervisors or city council is subject to the procedure or policy adopted by such board or council.

b. Local authorities must inform the department of any revocation and suspension of device retail permits by the local authority within 30 days of the suspension or revocation. Notification must be made electronically through GovConnectIowa unless the local authority has received permission from the director to use another method.

235.4(6) *Revocation for child support violations.*

a. The department will revoke a permit of a permit holder who is an individual if the department has received a certificate of noncompliance from child support services in regard to the permit holder unless the unit furnishes the department with a withdrawal of the certificate of noncompliance.

b. The board of supervisors or the city council that issued a retail permit is required by Iowa Code chapter 252J to revoke the permit of any retailer who is an individual if the board or council has received a certificate of noncompliance from child support services in regard to the retailer unless the unit furnishes the board or council with a withdrawal of the certificate of noncompliance.

235.4(7) *Waiting period.* Once the permit is revoked or suspended under this rule, the permittee cannot obtain another device retailer or device delivery sale permit, nor may a device retailer or device delivery sale permit be issued for the location covered by the revoked or suspended permit, regardless of the identity of the applicant, for a period of at least one year unless the applicant shows good cause to the contrary.

This rule is intended to implement Iowa Code chapter 252J and sections 453A.22 and 453E.7.

701—235.5(453E) Device retailers; age verification; display and entry.

235.5(1) *Age verification.* Before completing the sale of devices, device retailers must verify all purchasers are aged 21 or older as required in Iowa Code section 453E.3(8)*"a."*

235.5(2) *Display.*

a. Definitions.

"Generally display" includes displaying devices on shelves, counters, or cupboards visible only to those persons allowed entry to the retail establishment.

"Restrict entry" means the retailer actively checks the age of every person entering the establishment to ensure only persons who are at least 21 years of age enter.

b. Age restriction.

(1) All retail locations. Iowa Code chapter 453E provides that device retailers shall not display any devices in any part of a retail location where the devices are or could be visible to anyone younger than 21 years of age; however, the statute does not prescribe a specific method of display that prevents those under the age of 21 from viewing devices.

1. Device retailers cannot allow anyone younger than 21 years of age to view devices inside the retail establishment, including persons younger than 21 years of age who are accompanied by a parent or guardian.

2. Displaying devices in an external display window visible to the general public is prohibited.

3. Using signage such as "21 & OLDER ONLY" without checking the age of every person entering the establishment is not sufficient to restrict entry to the retail location.

(2) Retail locations with age restrictions for entry. If a retail location restricts entry to the entire retail establishment only to those who are at least 21 years of age and devices are not visible to the general public from outside the retail location, devices may be generally displayed within the retail establishment.

(3) Retail locations that do not restrict entry by age. In determining whether a manner of display is in compliance with Iowa Code chapter 453E and the rules herein, the following will be considered:

1. Displaying devices within a retail location openly on shelves, counters, or cupboards visible to anyone in the retail establishment is generally prohibited if the retail establishment does not restrict entry into the establishment to persons 21 years of age and older.

2. Displaying devices in a separate room in the retail location where only persons aged 21 years and older can enter and view the devices is permitted as long as persons under 21 years of age are restricted from entry into the separate room where the devices are displayed.

3. Displaying devices in nonstructural spaces within the retail establishment utilizing a screen, curtain, or similar material that restricts visibility to the device is permissible if only persons aged 21 years and older are permitted by the retailer to enter the nonstructural space and to view the devices.

4. Retailers must also ensure that, even after purchase by an authorized purchaser, devices are not visible to persons under 21 years of age while the devices remain within the retail establishment's premises. Methods for preventing visibility to persons under the age of 21 include the use of opaque wrapping, bags, or boxes in which a purchased device is placed after sale.

c. Examples.

EXAMPLE 1: Device Retailer A places a sign by the entrance of the retail establishment that says, "You must be at least 21 years of age to enter", does not monitor the age of every person who enters the establishment, and only removes persons from the store if they appear to be under 21 years of age. Because A does not restrict entry, A cannot generally display devices so they are visible to anyone inside the establishment.

EXAMPLE 2: Device Retailer B checks the identification of every person entering the establishment to ensure they are at least 21 years of age. Because B restricts entry, B may generally display devices so they are visible to anyone inside the establishment. However, B cannot display devices so they are visible to persons outside the establishment.

EXAMPLE 3: Device Retailer C stores devices on shelves behind an opaque curtain near the register. The devices are not visible while the curtain covers them. C monitors the curtain and only allows persons who verify they are at least 21 years of age to look behind the curtain. When permitted persons look behind the curtain, the devices are not visible to anyone else in the store. C permissibly prevents persons under 21 years of age from viewing devices in the nonstructural space of the establishment consistent with this rule.

EXAMPLE 4: Device Retailer D stores devices on shelves behind a locked, opaque door. The devices are not visible while the door is shut. C only opens the door when requested by a person who verifies they are at least 21 years of age. However, the devices are generally visible to anyone inside the store when the door is open, and D does not restrict entry or verify that no one younger than 21 years of age

is in the establishment before opening the door. Because persons younger than 21 years of age can view the devices when the door is open, D impermissibly allows persons younger than 21 years of age to view devices in violation of this rule.

235.5(3) *Sales through vending machines prohibited.* Devices cannot be sold through a vending machine.

This rule is intended to implement Iowa Code section 453E.3.

701—235.6(453E) Delivery sale requirements.

235.6(1) *Verification of recipient's age.*

a. Prior to finalizing a sale to the purchaser, the device delivery seller must verify that the purchaser is at least 21 years of age in one of the following ways:

(1) Use a commercially available database, or aggregate of databases, that is regularly used by government and businesses for the purpose of age and identity verification.

(2) Obtain a copy of a valid government-issued document that provides the name, address, and date of birth of the purchaser.

b. For each device delivery sale, the device delivery seller must retain proof that it verified the purchaser is at least 21 years of age. The delivery seller must retain this proof for at least five years after the delivery sale.

c. Before completing the delivery of devices, a person making delivery sales must perform all of the following:

(1) Obtain a valid form of identification from the recipient.

(2) Review the provided identification and verify that the identification:

1. Is valid;
2. Identifies the recipient; and
3. Establishes the recipient is 21 years of age or older.

d. The recipient of the device to be delivered must be a person aged 21 or older. Deliveries shall not be left:

(1) In a mail or post office box;

(2) In any unattended area inside or outside of a building, home, office or other location; or

(3) With anyone younger than 21 years of age.

e. No delivery shall be completed if the recipient is unable to provide or the delivery person is unable to verify a valid form of identification indicating the recipient is 21 years of age or older.

235.6(2) *Signature.*

a. A delivery person must obtain the signature of the recipient and verify that the recipient is aged 21 years or older before completing the device delivery.

b. Signatures can be collected via a paper or electronic form.

c. Delivery signature must include the date of delivery and the printed version of the recipient's name, along with the recipient's signature.

d. Device delivery sale permit holders must electronically submit records of delivered devices via GovConnectIowa. Such permit holders must also retain the records of delivered devices and provide these records when requested by the department as required by Iowa Code section 453E.4.

235.6(3) *Labels.*

a. Devices delivered by delivery sale directly to Iowa residents must be conspicuously labeled with the words, "CONTAINS DEVICE: SIGNATURE OF PERSON AGE 21 OR OLDER REQUIRED FOR DELIVERY."

b. Required labels must be directly on the package containing the device(s) and must not be placed on any type of wrapping, whether made of plastic or other material, that could be removed from the package containing the device(s).

c. Labels may use alternative language to that identified in paragraph 235.6(3)*"a"* only after approval by the director. Requests for alternative wording must be made to the director in writing and approved before any alternative wording can be used.

This rule is intended to implement Iowa Code section 453E.4.

701—235.7(453E) Attachment of tax.

235.7(1) *Device excise tax.* Retail sales and delivery sales of devices are subject to a device excise tax of 40 percent of the retail sales price of the device. In addition to the device excise tax, retail sales and delivery sales of devices are subject to the state sales tax and applicable local option sales tax.

a. Iowa Code section 453E.5(2)*"b"* provides information on what constitutes "retail sales price" and which elements are considered in its determination.

b. When a device is sold as a part of a bundled transaction, as defined in Iowa Code section 423.2(8), the 40 percent device excise tax applies to the entire retail sales price of the bundled transaction.

c. Examples.

(1) Sale in a jurisdiction with no local option sales tax. If a device has a retail sales price of $10, the sale of the device would be subject to a device excise tax of $4 and the state sales tax of $0.60. Therefore, a customer's total would be $14.60.

(2) Sale in a jurisdiction with a local option sales tax. If a device has a retail sales price of $10, the sale of the device would be subject to a device excise tax of $4 (40 percent of sales price), state sales tax of $0.60 (6 percent of sales price), and local option sales tax of $0.10 (1 percent of sales price). Therefore, a customer's total would be $14.70.

235.7(2) *Collection and remittance.* Device retailers and device delivery sellers must remit the sales, any applicable local option sales, and the device excise tax in the manner described in rule 701—235.8(453E) and 701—Chapter 202.

This rule is intended to implement Iowa Code sections 453E.4 and 453E.5.

701—235.8(453E) Filing returns and reports; payment of tax.

235.8(1) *Device excise tax return filing.*

a. Due date. Every device retailer and device delivery seller, including persons that sell devices at retail or by delivery sale without a device retailer or device delivery sale permit, must file a device excise tax return once per month. This monthly return is due on or before the last day of the month following the end of the month in which the tax was collected. For example, the device excise tax return for devices sold in the month of May must be filed on or before June 30.

b. Electronic filing. Device retailers and delivery sellers required to file a monthly device excise tax return shall file the return electronically through GovConnectIowa. A device retailer or delivery seller who is unable to file a return electronically may request permission from the director to file a paper return. A device retailer or delivery seller requesting such permission shall provide proof of its inability to file electronically.

c. Failure to timely file. Any returns that are not filed electronically through GovConnectIowa, without prior permission to file using another method, are treated as not validly filed returns. Device retailers and delivery sellers that do not timely and validly file returns as described in Iowa Code chapter 453E and this rule will be subject to any applicable penalties and interest.

235.8(2) *Reporting device excise taxes.*

a. A device retailer or delivery seller that has a reporting obligation but sold zero devices in the month must affirmatively indicate on the device excise tax return that the taxpayer has no device excise tax to report. A device retailer or delivery seller does this by making the appropriate indication on the electronic return. A device retailer or delivery seller who fails to do so will be treated as not reporting device excise taxes for that reporting period.

b. Example. Device Retailer A made no sales of devices during the month of June. A must still file a device excise tax return on or before July 31 that indicates it made zero sales during June. If A fails to timely file that return, A is subject to all applicable penalties for the failure to file.

235.8(3) *Device excise tax remittance.*

a. The device excise tax owed by a device retailer or device delivery seller must accompany the device excise tax return for the period in which the tax became due.

b. Device retailers and device delivery sellers filing a monthly device excise tax return electronically shall remit the excise tax electronically unless the person obtains permission from the director to remit taxes by another method before doing so.

c. Remittances transmitted electronically are considered made on the date the remittance is completed in GovConnectIowa.

235.8(4) *Required reporting method.* Any reports required by Iowa Code chapter 453E and these rules shall be filed electronically by device retailers and device delivery sellers through GovConnectIowa unless the person obtains permission from the director to file by another method before doing so. Required reports are due on or before the last day of the month following the end of the month to which the report applies and should be filed simultaneously with the device retailer or device delivery seller's device excise tax return(s).

235.8(5) *Due dates, weekends, and holidays.* Due dates that fall on a Saturday, Sunday, or holiday, as defined in Iowa Code section 421.9A, shall be treated in accordance with Iowa Code section 421.9A.

235.8(6) *Other required information.* Device retailers and device delivery sellers are also required to provide any other information requested by the department for the purpose of administering Iowa Code chapter 453E and these rules.

235.8(7) *Incorporation of Iowa Code chapter 423 and 701—Chapter 202.* Except as otherwise stated in this chapter, the requirements of Iowa Code chapter 423 and 701—Chapter 202 governing sales and use tax returns and remittance of tax apply to all device retailers and device delivery sellers.

This rule is intended to implement Iowa Code sections 453E.3(7), 453E.4, and 453E.5.

701—235.9(453E) Records; invoices.

235.9(1) *Records retention generally.* Every device retailer and device delivery seller shall keep, preserve, and make available to the department any records required by Iowa Code chapter 453E for a period of at least five years.

235.9(2) *Requirements.* Records kept, preserved, or made available pursuant to this rule will be considered inadequate by the department if the requirements of this rule are not met. The director may, in certain circumstances, authorize device retailers, device delivery sellers, and others subject to Iowa Code chapter 453E and these rules to keep records in a manner other than those prescribed in these rules. Any such authorization must be in writing.

235.9(3) *Examples of records.* The following is a nonexhaustive list of records subject to the provisions of this rule.

a. Device retailers.

(1) Records, including invoices, evidencing the purchase by the device retailer of devices.

(2) Detailed inventory records.

(3) Any other records required to be kept in the device delivery seller's capacity as a tobacco retailer.

b. Device delivery sellers.

(1) Records of devices delivered to purchasers that include the following information for each delivery sale:

1. Name of device manufacturer.
2. Quantity of devices delivered.
3. Name and address of recipient.
4. Verification of recipient's age.
5. Copy of recipient's signature.
6. Sales tax paid on the products sold pursuant to Iowa Code chapter 423.
7. Excise tax paid on the products sold pursuant to Iowa Code chapters 453A and 453E.

(2) Detailed inventory records.

(3) Any other records required to be kept in the device delivery seller's capacity as a tobacco retailer.

235.9(4) *Invoice forms.* Whenever an invoice is required to be prepared or kept by Iowa Code chapter 453E or these rules, at minimum, it must contain the following information:

a. Seller's name, address, and permit number.
b. Purchaser's name, address, and permit number (if any).
c. Date of sale.
d. All prices and discounts stated separately.
e. An indication as to whether devices are being sold with or without sales and device excise taxes included.
f. Origination and destination points.

This rule is intended to implement Iowa Code sections 453E.3(7) and 453E.4(4)*"e."*

701—235.10(453E) Federal or state law. Nothing in this chapter shall be construed to affect the provisions of any applicable federal or state law.

This rule is intended to implement Iowa Code section 453E.2(4).

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9708C

REVENUE DEPARTMENT[701]

Adopted and Filed

Rulemaking related to general requirements

The Revenue Department hereby amends Chapter 1000, "General Requirements," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 123.10 and 123.49 and 2025 Iowa Acts, House File 470.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 123.30, 123.33 and 123.49.

Purpose and Summary

The amendments to Chapter 1000 are responsive to 2025 Iowa Acts, House File 470. The legislation expands the definition of "mixed drink or cocktail" to include alcoholic beverages composed of wine or beer. The addition of wine and beer in the definition of "mixed drink or cocktail" also expanded the retail alcohol license classifications allowed to fill, sell, and serve mixed drinks or cocktails. Additionally, the legislation codified the requirements for mixed drinks or cocktails not for immediate consumption, commonly known as infusion; therefore, the Department is rescinding the now redundant and outdated rule 701—1000.19(123).

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9554C**. A public hearing was held on the following date(s):

- October 7, 2025

No one attended the public hearing. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 701—3.7(99G,123,421,17A).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve rule **701—1000.19(123)**.

ITEM 2. Amend rule 701—1000.22(123) as follows:

701—1000.22(123) Filling and selling of mixed drinks or cocktails in a container other than the original container. Class "C," special class "C" retail alcohol licensees, and special class "C" retail native wine licensees and the licensee's employees may fill and sell mixed drinks or cocktails in a container other than the original container subject to Iowa Code section 123.49(2)*"d"*(3) and this rule.

1000.22(1) *Definitions.*

"Alcoholic liquor," for the purposes of this rule, means the same as defined in Iowa Code section 123.3(5) and includes "native distilled spirits" as defined in Iowa Code section 123.3(34).

"Beer," for the purposes of this rule, means "beer" as defined in Iowa Code section 123.3(7) and includes "high alcoholic content beer" as defined in Iowa Code section 123.3(22).

"Mixed drink or cocktail," for the purposes of this rule, means the same as defined in Iowa Code section 123.3(32).

"Original container," for the purposes of this rule, means a vessel containing alcoholic liquor, beer, or wine that has been lawfully obtained and has been securely capped, sealed, or corked at the location of manufacture.

"Sealed container," for the purposes of this rule, means the same as defined in Iowa Code section ~~123.49(2)*"d"*(4)(a)~~ 123.49(2)*"d"*(4)(b).

"Tamper-evident," for the purposes of this rule, means the same as defined in Iowa Code section ~~123.49(2)*"d"*(4)(b)~~ 123.49(2)*"d"*(4)(c).

"Wine," for the purposes of this rule, means "wine" as defined in Iowa Code section 123.3(53) and includes "native wine" as defined in Iowa Code section 123.3(36).

1000.22(2) *Filling conditions.*

a. A sealed container may be filled and sold only by the licensee or the licensee's employees who are 18 years of age or older.

b. A sealed container may be filled only upon receipt of an order by a consumer of legal age.

c. A sealed container may be filled only with mixed drinks or cocktails composed in whole or in part with alcoholic liquor, beer, or wine from an original container purchased ~~from a class "E" retail alcohol licensee~~ as prescribed by Iowa Code chapter 123.

d. The filling of a sealed container needs to be conducted in compliance with applicable state and federal food safety statutes and regulations at all times.

1000.22(3) to **1000.22(7)** No change.

This rule is intended to implement Iowa Code sections 123.30, 123.33, and 123.49.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9709C

REVENUE DEPARTMENT[701]

Adopted and Filed

Rulemaking related to general requirements

The Revenue Department hereby amends Chapter 1000, "General Requirements," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 123.10 and 123.37.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 123.4, 123.10, 123.24, 123.30 and 123.37.

Purpose and Summary

The purpose of this rulemaking is to provide updated Department processes. Rule 701—1000.28(123) is being amended to accurately reflect the fee charged to class "E" licensees for dishonored payment of alcoholic liquor purchases and to include the option of using a surety bond to satisfy outstanding obligations to the Department for alcoholic liquor payments.

Additionally, the Department is directed under Iowa Code section 123.37(4) to adopt rules establishing procedures for payment of disputed taxes imposed under Iowa Code chapter 123. The new rule provides class "A" and special class "A" beer permittees, class "A" wine permittees, and wine direct shipper permittees with the procedure on how to dispute the taxes and related penalties they are subject to under Iowa Code chapter 123.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9555C**. A public hearing was held on the following date(s):

- October 7, 2025

No one attended the public hearing. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa. Pursuant to subrule 1000.28(2), the Department will be able to collect a fee in the exact amount charged by the financial institution providing payment services and the Department will not absorb any additional costs.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 701—3.7(99G,123,421,17A).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Amend rule 701—1000.28(123) as follows:

701—1000.28(123) Dishonored payment for alcoholic liquor.

1000.28(1) *Certified funds status.* If a class "E" retail alcohol licensee tenders payment for alcoholic liquor that is subsequently dishonored, the licensee will enter a certified funds status for a duration determined by the director. During the certified funds status period, the licensee will tender a bank draft in exact payment in advance of the licensee's alcoholic liquor delivery.

1000.28(2) *Fee.* ~~The department may collect from the licensee a $20 fee for each dishonored payment for the purchase of alcoholic liquor.~~ For each dishonored payment for the purchase of alcoholic liquor, the department may collect a fee in the exact amount charged by the financial institution providing payment services.

1000.28(3) *Automatic license renewal.* Any class "E" retail alcohol licensee that is enrolled in automatic license renewal and tenders payment for alcoholic liquor that is subsequently dishonored will be unenrolled from automatic license renewal.

1000.28(4) *Bond collection.* The director may collect from a surety bond in order to satisfy any outstanding obligations for dishonored payments.

This rule is intended to implement Iowa Code sections 123.4, 123.24, 123.30, and 123.35.

ITEM 2. Adopt the following **new** rule 701—1000.32(123):

701—1000.32(123) Procedures for disputed beer barrel and wine gallonage taxes. This rule governs the application of payments for all taxes and penalties imposed under Iowa Code chapter 123.

1000.32(1) *Requirements.* Class "A" and special class "A" beer permittees, class "A" wine permittees, and wine direct shipper permittees are required to file and pay taxes and related penalties as required by Iowa Code chapter 123.

1000.32(2) *Notice of assessment.* Taxes are subject to audits performed by the department. Upon the completion of an audit, the department will send the permittee an audit findings letter and notice of assessment. A permittee has 30 days to dispute the findings provided by the notice of assessment.

1000.32(3) *Appeal process.*

a. Pursuant to Iowa Code section 123.37, a permittee who disputes the amount of tax imposed must pay all tax and penalty pertaining to the disputed tax liability prior to appealing the disputed tax liability to the director.

b. Once all tax and penalty liabilities are paid, a permittee must follow the procedures outlined in rule 701—6.4(99G,123,17A) to request an appeal. Once received, the appeal will then proceed in accordance with 701—Chapter 6.

c. Assessed tax liabilities can be compromised and settled with the department at any time throughout the appeal process.

This rule is intended to implement Iowa Code section 123.37.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9711C

SECRETARY OF STATE[721]

Adopted and Filed

Rulemaking related to election forms and instructions

The Secretary of State hereby amends Chapter 21, "Election Forms and Instructions," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 49.124.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 49.124.

Purpose and Summary

This rulemaking creates a required course of training that county commissioners of elections will provide to their poll workers.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on May 14, 2025, as **ARC 9194C**.

Conversations with county auditors were had, and updates were made based on those conversations.

Adoption of Rulemaking

This rulemaking was adopted by the Secretary of State on October 13, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Rulemaking deals with statutory authority of the Secretary of State over county auditors in the conduct of elections. Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Secretary of State for a waiver of the discretionary provisions, if any, pursuant to 721—Chapter 10.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** rule 721—21.362(49):

721—21.362(49) Precinct election officials and other election personnel training requirements.

21.362(1) The commissioner shall conduct, not later than the day before each election, a training course necessary and appropriate to the roles of all election personnel. The personnel shall include all precinct election officials and any other persons who will be employed in or around the polling places on election day by the commissioner. For purposes of this rule, election day includes any voting at the commissioner's office or a satellite location.

21.362(2) The training that is necessary and appropriate to the roles of election personnel, which the commissioner may combine with election-specific materials, shall include subjects established yearly in policy by the state commissioner. Once a year, all precinct election officials shall receive a complete annual training, and before every election all precinct election officials shall receive a refresher training course.

This rule is intended to implement Iowa Code chapter 49.

[Filed 10/13/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9712C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to placement

The Workforce Development Department hereby rescinds Chapter 54, "Placement," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A and section 84A.1.

Purpose and Summary

The purpose of this rulemaking is to remove a chapter that references outdated citations.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9545C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 54**.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9713C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to youth affairs

The Workforce Development Department hereby rescinds Chapter 56, "Youth Affairs," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A and section 84A.1.

Purpose and Summary

The purpose of this rulemaking is to rescind a chapter that references outdated citations.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9546C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 56**.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9714C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to work force investment program

The Workforce Development Department hereby rescinds Chapter 57, "Work Force Investment Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A and section 84A.1.

Purpose and Summary

The purpose of this rulemaking is to rescind a chapter that references outdated citations.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9547C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 57**.

[Filed 10/22/25, effective 12/17/25]
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ARC 9715C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to Iowa job training partnership program

The Workforce Development Department hereby rescinds Chapter 58, "Iowa Job Training Partnership Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 17A and 84A.

Purpose and Summary

The purpose of this rulemaking is to rescind a chapter that references outdated citations.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9548C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 58**.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9716C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to mentor advisory board

The Workforce Development Department hereby rescinds Chapter 59, "Mentor Advisory Board," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 17A and 84A.

Purpose and Summary

The purpose of this rulemaking is to rescind a chapter that references outdated citations.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9549C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 59**.

[Filed 10/22/25, effective 12/17/25]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9717C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to strategic workforce development fund

The Workforce Development Department hereby rescinds Chapter 61, "Strategic Workforce Development Fund," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 17A and 84A.

Purpose and Summary

The purpose of this rulemaking is to rescind a chapter that references outdated citations.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9552C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 61**.

[Filed 10/22/25, effective 12/17/25]
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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9718C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to workforce development fund

The Workforce Development Department hereby rescinds Chapter 64, "Workforce Development Fund," Iowa Administrative Code, and adopts a new Chapter 64 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 17A and 84A.

Purpose and Summary

Chapter 64 provides administrative rules for the allocation of workforce development funds as per Iowa Code chapter 260F.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9542C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 871—Chapter 64 and adopt the following **new** chapter in lieu thereof:

CHAPTER 64
WORKFORCE DEVELOPMENT FUND

871—64.1(15,76GA,ch1180) Purpose. The purpose of the workforce development fund is to provide revenue for programs that address the workforce development needs of the state. Moneys are appropriated to the fund from the workforce development fund account and are to be used for projects under Iowa Code chapter 260F.

871—64.2(15,76GA,ch1180) Definitions.

"Agreement" means an informal agreement between the department and a grantee that authorizes expenditure of a workforce development fund award.

"Contract" means a formal agreement executed by the department and a grantee for purposes of operating a program under the workforce development fund.

"Department" or *"IWD"* means Iowa workforce development.

"Director" means the director of Iowa workforce development.

"Grantee" means any entity receiving a workforce development fund award from Iowa workforce development.

871—64.3(15,76GA,ch1180) Workforce development fund account. A workforce development fund account is established in the office of the treasurer of state under control of the department. Upon payment in full of a certificate of participation or other obligation issued to fund a job training program under Iowa Code chapter 260E, including a certificate of participation repaid in whole or in part by the supplemental new jobs credit from withholding under Iowa Code section 260J.1, the community college providing the job training program will notify the department of the amount paid by the employer or business to the community college to retire the certificate during the last 12 months of withholding collections. The department will notify the department of revenue of that amount. The department of revenue will then credit to the workforce development fund account, established in Iowa Code section 84G.3, 25 percent of that amount each quarter for a period of ten years. If the amount of withholding from the business or employer is insufficient, the department will prorate the quarterly amount credited to the workforce development fund account. The maximum amount from all employers that will be transferred to the workforce development fund account in any year is $7,750,000. The legislature will make an annual appropriation from the workforce development fund account to the workforce development fund.

871—64.4(15,76GA,ch1180) Workforce development fund allocation. The director will submit a copy of the proposed allocation of funds from the workforce development fund to be made for the next fiscal year for the programs and purposes intended to the chairpersons of the joint economic development appropriations subcommittee of the general assembly. Notwithstanding Iowa Code section 8.39, the plan may provide for increased or decreased allocations if the demand for a program indicates that the need is greater or lesser than the allocation for that program. Workforce development funds are received quarterly. The sequence in which the funds are allocated to the various programs under the workforce development fund will be determined by the department based upon the demand for the respective programs.

871—64.5(15,76GA,ch1180) Workforce development fund reporting. The director will provide annual reports to the legislative services agency on the status of the funds. Unobligated and unencumbered moneys remaining in the workforce development fund or any of its accounts on June 30 of each year will be considered part of the fund for purposes of the next year's allocation.

These rules are intended to implement Iowa Code chapter 260F.

[Filed 10/22/25, effective 12/17/25]
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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.

ARC 9719C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to employment agency licensing

The Workforce Development Department hereby rescinds Chapter 78, "Employment Agency Licensing," Iowa Administrative Code, and adopts a new Chapter 78 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code chapters 17A and 84I.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 84I.

Purpose and Summary

The purpose of this rulemaking is to update outdated references and remove restrictive terms.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 17, 2025, as **ARC 9553C**. Public hearings were held on the following date:

- October 7, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Director of the Department on October 22, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on December 17, 2025.

The following rulemaking action is adopted:

ITEM 1. Rescind 871—Chapter 78 and adopt the following **new** chapter in lieu thereof:

Title V
EMPLOYMENT AGENCY LICENSING

CHAPTER 78
EMPLOYMENT AGENCY LICENSING

871—78.1(84I) Definitions. In addition to the definitions found in Iowa Code chapter 84I, the following definition applies:

"Agency" means employment agency.

871—78.2(84I) Application and license.

78.2(1) *Application.* An application for a license must be made in writing to the director on the form provided by the director. The applicant shall also complete and submit the employee-paid fee schedule form provided by the director, the $75 nonrefundable fee, and all contract forms to be signed by an employee. The application shall also be accompanied by a surety company bond in the sum of $30,000, to be approved by the director and conditioned to pay any damages that may accrue to any person due to a wrongful act or violation of law on the part of the applicant in the conduct of business.

78.2(2) *Name.* No agency shall use any name, symbol or abbreviation deceptively similar to or reasonably likely to be confused with the name used by an existing agency, any governmental unit, or any nonprofit organization.

78.2(3) *Change in officers.* A change in the name of any person required to be reported on the application under Iowa Code chapter 84I shall be forwarded to the director within ten days of the change.

78.2(4) *Change in address.* The agency shall notify the director of any change of address prior to the change.

78.2(5) *Multiple locations.* A separate license shall be required for each separate office location operated by an agency.

78.2(6) *Nontransferable.* A license is nontransferable.

871—78.3(84I) Nonemployment agency activity. The following activities do not require an employment agency license:

1. Appraisal of an employee's qualifications.
2. Development of career goals and marketing plans.
3. Preparation and printing of résumés.
4. Instruction on interview techniques and networking.
5. Counseling on negotiating pay and fringe benefits.
6. Assistance in obtaining employment when provided by schools, colleges, trade unions, and similar organizations for their students or members if any fees paid are for tuition, training, or dues and would be charged even if the student or member did not attempt to utilize the organization's employment search services.
7. Furnishing or procuring theatrical, stage, or platform attractions or amusement enterprises.
8. Any activity by a governmental unit.

871—78.4(84I) Complaints. Written complaints by an aggrieved party will be investigated. The director will notify the aggrieved party in writing of the outcome of the investigation. The director may take any appropriate action, including denial, revocation, reprimand, and suspension.

871—78.5(17A,84I,252J) Denials, revocations, reprimands and suspensions.

78.5(1) The director may deny, revoke, or suspend a license or issue a reprimand when the director finds that any of the following conditions exist:

a. The license applicant has violated any of the provisions of Iowa Code chapter 84I or the rules of this chapter;

b. The child support recovery unit of the department of health and human services has issued a certificate of noncompliance to an employment agency; or

c. The license application or its required attachments are inaccurate, incomplete or otherwise insufficient.

78.5(2) Contested cases shall be governed by Iowa Code chapter 17A and 481—Chapter 10.

871—78.6(84I) Permissible fees charged by agency.

78.6(1) The total amount charged to any employee in any form by an agency shall not exceed 15 percent of the employee's gross earnings from that employer for which the agency procured the job in any pay period for a period of time not to exceed the first 12 months from the date of employment.

78.6(2) Fees due the agency are payable as earned; however, the employee may knowingly agree to pay the fee in advance, with the full understanding that the employee is not required to do so, and the agency guarantees to refund any amounts in excess of 15 percent of actual gross earnings, when ascertained.

78.6(3) No agency or any person connected therewith shall require any employee to execute any negotiable instrument, assignment of earnings, or note except for that amount of fee that is past due to the agency.

78.6(4) Each agency shall keep conspicuously posted at its place of business a copy of the agency's schedule of fees on file with the director. The schedules shall be printed in not less than 8-point type.

78.6(5) Each employee who has paid the fee in advance must be notified at the employee's last-known address by the agency at the time the employee makes the final payment on the fee that the employee may have a refund due if the employee has paid more than 15 percent of the gross earnings of the employee's first year of employment.

871—78.7 Reserved.

871—78.8(84I) Contracts and fee schedules.

78.8(1) *Schedules furnished.* Any schedule of fees to be charged by an agency to employees shall be furnished to all employees at the time of making an application with the agency.

78.8(2) *Required content of all contracts.*

a. Contracts and fee schedules shall not contain smaller than 8-point type.

b. Contracts and fee schedules shall contain no ambiguous, false or misleading information.

c. All contracts and fee schedules must clearly state that the agency is licensed by Iowa Workforce Development and that inquiries may be made via mail to Iowa Workforce Development, 1000 East Grand Avenue, Des Moines, Iowa 50319, or by telephone to 1.866.239.0843.

78.8(3) *Additional required content for employee-paid fee contracts.*

a. Each employee-paid fee contract shall contain a provision limiting to one year from the date of referral the period for which an agency may assess a placement fee for referral of that employee to that employer.

b. Where the agency provides the option for advance payment, the contract and employee-paid fee schedule must clearly state that the employee knowingly agrees to pay the fee in advance with the full understanding that the employee is not required to do so and that the agency guarantees to refund any amount in excess of 15 percent of the employee's gross earnings from that employer for which the agency procured the job for a period of time not to exceed the first 12 months from the date of employment, when ascertained.

c. All employee-paid fee contracts and fee schedules must state the fee in dollar amounts as well as percentages.

These rules are intended to implement Iowa Code chapter 84I.

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