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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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).

Schedule for Rulemaking—2025

REGULATORY ANALYSIS SUBMISSION DEADLINE	REGULATORY ANALYSIS PUB. DATE	HEARING AND COMMENTS 20 DAYS	FIRST † POSSIBLE NOTICE SUBMISSION DEADLINE	NOTICE PUB. DATE	HEARING OR COMMENTS 20 DAYS	FIRST POSSIBLE ADOPTION DATE 35 DAYS	ADOPTED FILING DEADLINE	ADOPTED PUB. DATE	FIRST POSSIBLE EFFECTIVE DATE 35 DAYS	FIRST POSSIBLE EXPIRATION OF NOTICE 180 DAYS
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****

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."

Other autonomous agencies are included alphabetically in SMALL CAPITALS at the left-hand margin.

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The Administrative Rules Review Committee will hold its regular, statutory meeting on Monday, January 12, 2026, at 8 a.m. in Room 116, State Capitol, Des Moines, Iowa. For more information, contact Jack Ewing at jack.ewing@legis.iowa.gov. The following rules will be reviewed:

ECONOMIC DEVELOPMENT AUTHORITY[261]

Length of service awards program grant fund, ch 21 Filed **ARC 9857C** 12/24/25
Workforce housing tax incentive program, ch 48 Notice **ARC 9830C** 12/24/25
Employer child care tax credit; assistive device tax credit; aggregate tax credit limit for certain economic development programs, rescind chs 57, 66, 76 Notice **ARC 9850C** 12/24/25
Redevelopment tax credits program, ch 65 Notice **ARC 9832C** 12/24/25
Business incentives for growth (BIG) program, ch 69 Filed **ARC 9858C** 12/24/25
Research and development tax credit program, ch 82 Notice **ARC 9828C** 12/24/25
Small business innovation research and technology transfer outreach program (America's seed fund), ch 106 Notice **ARC 9831C** 12/24/25
Reinvestment districts program, ch 200 Notice **ARC 9833C** 12/24/25
Iowa major events and tourism program, ch 201 Notice **ARC 9829C** 12/24/25
Community attraction and tourism (CAT) program, ch 211 Notice **ARC 9834C** 12/24/25
Sports tourism program: marketing fund, rescind ch 215 Notice **ARC 9849C** 12/24/25
Sports tourism infrastructure program, ch 216 Notice **ARC 9835C** 12/24/25
Iowa film production incentive program and fund, ch 300 Notice **ARC 9827C** 12/24/25

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Abuse of students by school employees—investigation, charges, amendments to ch 102 Filed **ARC 9813C** 12/10/25

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HIGHER EDUCATION LOAN AUTHORITY[284]

EDUCATION DEPARTMENT[281]"umbrella"
Organization and operations, ch 1 Notice **ARC 9866C** 12/24/25
Petitions for rulemaking, ch 2 Notice **ARC 9867C** 12/24/25
Declaratory orders, ch 3 Notice **ARC 9868C** 12/24/25
Agency procedure for rulemaking, ch 4 Notice **ARC 9869C** 12/24/25
Public records and fair information practices, ch 5 Notice **ARC 9870C** 12/24/25

HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]

Organization, ch 1 Filed **ARC 9815C** 12/10/25
Uniform rules on agency procedure, adopt ch 2; rescind chs 3 to 6 Filed **ARC 9816C** 12/10/25
Iowa comprehensive plan, ch 9 Filed **ARC 9817C** 12/10/25
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Emergency assistance, ch 11 Notice **ARC 9824C** 12/24/25
Natural hazard mitigation financing program, ch 16 Filed **ARC 9818C** 12/10/25

HUMAN SERVICES DEPARTMENT[441]

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Amount, duration and scope of medical and remedial services, ch 78 Notice **ARC 9865C** 12/24/25

Other policies relating to providers of medical and remedial care, ch 79 Notice **ARC 9852C** 12/24/25
Procedure and method of payment, ch 80 Notice **ARC 9851C** 12/24/25
State supplementary assistance—increase in personal needs allowance, 81.13(2), 81.18, 82.16, 85.20 Filed **ARC 9859C** 12/24/25
Medicaid waiver services, ch 83 Notice **ARC 9856C** 12/24/25
Family planning program, ch 87 Filed **ARC 9819C** 12/10/25
Fee-for-service case management, ch 90 Notice **ARC 9854C** 12/24/25
Protective locked environment, 105.1, 105.8(10), 106.1, 114.2, 115.2, 115.6, 115.7 Notice **ARC 9845C** 12/24/25
Certificate of need program; standards for certificate of need review, chs 123, 124 Notice **ARC 9796C** 12/10/25
Kinship foster care approval standards, ch 125 Notice **ARC 9846C** 12/24/25
Juvenile court-ordered services, ch 151 Notice **ARC 9847C** 12/24/25
Subsidized adoption maintenance rate increase, 201.5(6) Filed **ARC 9860C** 12/24/25
Opioid settlement fund disbursement, ch 306 Notice **ARC 9844C** 12/24/25

INSPECTIONS AND APPEALS DEPARTMENT[481]

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IOWA FINANCE AUTHORITY[265]

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Home and community-based services revolving loan program, ch 21 Notice **ARC 9798C** 12/10/25
Water pollution control works and drinking water facilities financing program, ch 26 Filed **ARC 9821C** 12/10/25
Military service member home ownership assistance program, ch 27 Notice **ARC 9826C** 12/24/25
Wastewater and drinking water treatment financial assistance program, ch 28 Filed **ARC 9822C** 12/10/25
HOME investment partnerships program, ch 39 Notice **ARC 9797C** 12/10/25
Community housing and services for persons with disabilities revolving loan program, ch 43 Notice **ARC 9799C** . . 12/10/25
Water quality financing program, ch 46 Filed **ARC 9823C** 12/10/25

RACING AND GAMING COMMISSION[491]

INSPECTIONS AND APPEALS DEPARTMENT[481]"umbrella"

Racing, gambling structure, or excursion gambling boat license application—refundable fees, 1.5(1) Notice **ARC 9803C** 12/24/25
Greyhound racing, rescind ch 7 Notice **ARC 9800C** 12/24/25
Pari-mutuel wagering, simulcasting and advance deposit wagering, ch 8 Notice **ARC 9801C** 12/24/25
Thoroughbred and quarter horse racing, ch 10 Notice **ARC 9802C** 12/24/25

TRANSPORTATION DEPARTMENT[761]

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City requests for closure of primary road extensions, rescind ch 151 Filed **ARC 9861C** 12/24/25
Notification of railroad accidents or incidents, ch 802 Notice **ARC 9791C** 12/10/25
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War orphans educational assistance fund, rescind ch 9 Notice **ARC 9841C** 12/10/25
Vietnam conflict veterans bonus, rescind ch 13 Notice **ARC 9842C** 12/10/25
Limited residency Vietnam conflict veterans bonus, rescind ch 16 Notice **ARC 9843C** 12/10/25

WORKFORCE DEVELOPMENT DEPARTMENT[871]
Definitions, ch 48 Filed **ARC 9862C** 12/24/25
Employment and training services divisions, ch 49 Filed **ARC 9863C** 12/24/25
Iowa workforce investment Act program, rescind ch 53 Filed **ARC 9864C** 12/24/25

ADMINISTRATIVE RULES REVIEW COMMITTEE MEMBERS

Regular, statutory meetings are held each month at the seat of government as provided in Iowa Code section 17A.8. A special meeting may be called by the Chair at any place in the state and at any time.

Senator Dave Rowley
Vice Chair
Senate District 5

Senator Mike Bousselot
Senate District 21

Senator Dan Dawson
Senate District 10

Senator Janet Petersen
Senate District 18

Senator Cindy Winckler
Senate District 49

Representative Chad Ingels
Chair
House District 68

Representative Amy Nielsen
House District 85

Representative Rick Olson
House District 39

Representative Ryan Weldon
House District 41

Representative David Young
House District 28

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ARC 9830C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to workforce housing tax incentives program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 48, "Workforce Housing Tax Incentives Program," Iowa Administrative Code and to adopt a new Chapter 48 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 15.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 48 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Workforce Housing Tax Incentive Program available pursuant to Iowa Code chapter 15, subchapter II, part 17, as amended by 2025 Iowa Acts, Senate File 657. The program supports the development of housing projects that are targeted at middle-income households.

The new chapter is clearer and more concise throughout and omits language that duplicates statute. Additionally, the new chapter omits inconsistencies due to 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 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 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 January 15, 2026. 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:

January 13, 2026 9:30 to 9:45 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
January 15, 2026 9:30 to 9:45 a.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 48 and adopt the following **new** chapter in lieu thereof:

CHAPTER 48
WORKFORCE HOUSING TAX INCENTIVES PROGRAM

261—48.1(15) Definitions. As used in this chapter unless the context otherwise requires:

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

"Authority's website" means the information and related content found at www.opportunityiowa.gov.

"Average dwelling unit cost" means the costs directly related to the housing project divided by the total number of dwelling units in the housing project.

"Board" means the same as defined in Iowa Code section 15.102.

"Costs directly related" means expenditures that are incurred for construction of a housing project to the extent that they are attributable directly to the improvement of the property or its structures. "Costs directly related" includes expenditures for site preparation work, surveying, construction materials, construction labor, architectural services, and engineering services. "Costs directly related" does not include expenditures for property acquisition, building permits, building inspection fees, furnishings, appliances, accounting services, legal services, loan origination and other financing costs including interest on construction loans, syndication fees and related costs, developer fees, or the costs associated with selling or renting the dwelling units whether incurred before or after completion of the housing project.

"Disaster recovery housing project" means the same as defined in Iowa Code section 15.354(6).

"Grayfield site" means the same as defined in Iowa Code section 15.352.

"Greenfield site" means the same as defined in Iowa Code section 15.352.

"Housing business" means the same as defined in Iowa Code section 15.352.

"Housing project" means the same as defined in Iowa Code section 15.352.

"New dwelling units" means dwelling units that are made available for occupancy in a community as a result of a housing project and that were not available for occupancy as residential housing in the community for a period of at least six months prior to the date on which application is made to the authority for tax incentives. If a dwelling unit has served as residential housing and been occupied during the six months preceding the date on which application is made to the authority for tax incentives, then the dwelling unit shall be presumed not to be a new dwelling unit.

"Program" means the workforce housing tax incentives program administered pursuant to Iowa Code chapter 15, subchapter II, part 17, and this chapter.

"Tax credit certificate" means a certificate issued by the authority stating the amount of workforce housing investment tax credits pursuant to Iowa Code section 15.355(3) that an eligible housing business may claim.

261—48.2(15) Housing project requirements.

48.2(1) *Eligible project types.* To receive workforce housing tax incentives pursuant to the program, a proposed housing project shall meet all of the requirements in Iowa Code section 15.353.

a. For the purposes of identifying eligible project types pursuant to Iowa Code section 15.353, "rehabilitation, repair, or redevelopment" means construction or development activities associated with a housing project that are undertaken for the purpose of reusing or repurposing existing buildings or structures as new dwelling units. "Rehabilitation, repair, or redevelopment" does not include new construction of dwelling units at a greenfield site. "Rehabilitation, repair, or redevelopment" includes new structures at a qualified grayfield site.

b. For the purposes of identifying eligible project types pursuant to Iowa Code section 15.353, factors the authority may consider to determine whether a dwelling unit should be classified as a single family dwelling unit include but are not limited to the following:

(1) Whether the unit is separated from other units by a ground-to-roof wall;

(2) Whether the unit has a separate heating system;

(3) Whether the unit has an individual meter for public utilities; and

(4) Whether the unit has other units above or below.

c. A housing project is not eligible for the program if it is located in a 100-year floodplain.

48.2(2) *Maximum cost.* The average dwelling unit cost for a housing project shall not exceed the maximum amount established by the board pursuant to Iowa Code section 15.353(3)*"a"* or, if applicable, the maximum amount established pursuant to Iowa Code section 15.353(3)*"b."*

48.2(3) *Violations of law.* A housing project may be ineligible for the program due to a record of violations of the law pursuant to Iowa Code section 15.354(1)*"b"*(2) as amended by 2025 Iowa Acts, Senate File 657.

261—48.3(15) Housing project application and agreement.

48.3(1) *Application.* Information about applying for tax incentives will be available on the authority's website. A housing business shall apply for tax incentives in the form and content specified by the authority. The application will include all the information described in described in Iowa Code section 15.354(1).

48.3(2) *Application review and approval.*

a. All completed applications shall be reviewed and scored pursuant to Iowa Code section 15.354(2) as amended by 2025 Iowa Acts, Senate File 657. Review criteria include but are not limited to project need, project readiness, financial capacity, and project impact.

b. The director will approve tax incentive awards after considering the recommendations of staff. The director may approve, defer or deny an application.

48.3(3) *Agreement and fees.*

a. A housing business that has been approved for tax incentives shall execute and return the agreement required by Iowa Code section 15.354(3) within 90 days of transmittal. Failure to do so may be cause for the director to terminate the award.

b. The compliance cost fees imposed in Iowa Code section 15.354(3)*"b"* as amended by 2025 Iowa Acts, Senate File 657, shall apply to all agreements entered into for this program.

c. The agreement entered pursuant to Iowa Code section 15.354(3) may only be amended if done so in writing and signed by the housing business and the authority. Examples of situations requiring an amendment include but are not limited to time extensions, budget revisions, and significant alterations of the housing project.

d. Upon completion of a housing project, a housing business shall submit all of the information and documentation required by Iowa Code section 15.354(3)*"d"* to the authority along with a statement of all funding sources utilized for the project including government financing. The attestation applicable to the examination required by Iowa Code section 15.354(3)*"d"* is SSAE No. 10 (as amended by SSAE Nos. 11, 12, 14), AT section 101, and AT section 601 or other comparable attestations as identified by the authority. The procedures used by the certified public accountant (CPA) to conduct the examination should allow the CPA to conclude that, in the CPA's professional judgment, the expenditures claimed are eligible pursuant to the agreement; Iowa Code chapter 15, subchapter II, part 17; and all rules adopted pursuant to Iowa Code chapter 15, subchapter II, part 17, in all material respects. Within ten business days of a request by the authority, the housing business shall make available to the authority the documents reviewed by the CPA unless good cause is shown.

261—48.4(15) Workforce housing tax incentives.

48.4(1) *Eligibility.* A housing business that has entered into an agreement pursuant to rule 261—48.3(15) is eligible to receive the sales tax refund and income tax credit described in Iowa Code section 15.355. Tax incentives may be claimed pursuant to Iowa Code section 15.355 and any applicable rules adopted by the department of revenue.

48.4(2) *Transfer.* Tax credit certificates may be transferred to any person pursuant to Iowa Code section 15.355 and the applicable rules adopted by the department of revenue. However, tax credit certificate amounts of less than $1,000 shall not be transferable.

48.4(3) *Tax credit limitations.* The tax credit limitations specified in Iowa Code section 15.354(4) as amended by 2025 Iowa Acts, Senate File 657, shall apply.

DISASTER RECOVERY HOUSING PROGRAM

261—48.5(15) Disaster recovery housing project requirements. To receive disaster recovery housing tax incentives pursuant to the program, a proposed disaster recovery housing project shall meet all requirements for other housing projects in rule 261—48.2(15).

261—48.6(15) Disaster recovery housing project application and agreement.

48.6(1) *Application.* Information about applying for disaster recovery tax incentives will be available on the authority's website. A housing business shall apply for tax incentives in the form and with the content specified by the authority. The application will include all the information described in Iowa Code section 15.354(1). If tax credits for disaster recovery housing projects are available, the authority may establish a disaster recovery application period following the declaration of a major disaster by the President of the United States for a county in Iowa.

48.6(2) *Application review and approval.*

a. All completed applications shall be reviewed and scored pursuant to Iowa Code section 15.354(2) as amended by 2025 Iowa Acts, Senate File 657. Review criteria include but are not limited to project need, project readiness, financial capacity, and project impact.

b. The director will approve tax incentive awards after considering the recommendations of staff. The director may approve, defer, or deny an application.

48.6(3) *Agreement and fees.*

a. A housing business that has been approved for disaster recovery tax incentives shall execute and return the agreement required by Iowa Code section 15.354(3) within 90 days of transmittal. Failure to do so may be cause for the director to terminate the award.

b. The compliance cost fees imposed in Iowa Code section 15.354(3)*"b"* as amended by 2025 Iowa Acts, Senate File 657, shall apply to all agreements entered into for this program.

c. The agreement entered pursuant to Iowa Code section 15.354(3) may only be amended if done so in writing and signed by the housing business and the authority. Examples of situations requiring an amendment include but are not limited to time extensions, budget revisions, and significant alterations of the housing project.

d. Upon completion of a disaster recovery housing project, a housing business shall submit all information and documentation required by Iowa Code section 15.354(3)*"d"* to the authority along with a statement of all funding sources utilized for the project including government financing. The attestation applicable to the examination required by Iowa Code section 15.354(3)*"d"* is as described in paragraph 48.3(3)*"c."*

261—48.7(15) Disaster recovery housing tax incentives.

48.7(1) *Eligibility.* A housing business that has entered into an agreement pursuant to rule 261—48.6(15) is eligible to receive the sales tax refund and income tax credit described in Iowa Code section 15.355. Tax incentives may be claimed pursuant to Iowa Code section 15.355 and any applicable rules adopted by the department of revenue.

48.7(2) *Transfer.* Tax credit certificates may be transferred to any person pursuant to Iowa Code section 15.355 and the applicable rules adopted by the department of revenue. However, tax credit certificate amounts of less than $1,000 shall not be transferable.

48.7(3) *Tax credit limitations.* The tax credit limitations specified in Iowa Code section 15.354(4) as amended by 2025 Iowa Acts, Senate File 657, or that may otherwise be specified for disaster recovery housing projects shall apply.

261—48.8(15) Projects located in small cities. A housing project located in a city or township that meets the criteria in Iowa Code section 15.352(10)*"b"* must be located at least five miles from the city limits of a city with a population greater than 2,500 to be considered located in a small city. Population for the purposes of this rule will be as determined by either the most recent population estimate produced by the United States Bureau of Census or the most recent decennial census released by the United States Bureau of Census.

These rules are intended to implement Iowa Code chapter 15, subchapter II, part 17.

ARC 9850C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to tax credits and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 57, "Employer Child Care Tax Credit," Chapter 66, "Assistive Device Tax Credit," and Chapter 76, "Aggregate Tax Credit Limit for Certain Economic Development Programs," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 15.119, 237A.31 and 422.33(9).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 15.119, 237A.31 and 422.33(9) and 2025 Iowa Acts, Senate File 657.

Purpose and Summary

Pursuant to Executive Order 10 and Iowa Code section 17A.7(2), the Authority proposes to rescind Chapters 57, 66, and 76. Chapter 57 describes the policies and procedures applicable to the Employer Child Care Tax Credit administered by the Authority pursuant to Iowa Code section 237A.31. Chapter 66 describes the policies and procedures applicable to the Assistive Device Tax Credit administered by the Authority pursuant to Iowa Code section 422.33(9). Chapter 76 describes the procedure by which the Authority, with approval of its Board, allocates the aggregate tax credit limit established in Iowa Code section 15.119.

The Employer Child Care Tax Credit and Assistive Device Tax Credit were repealed by 2025 Iowa Acts, Senate File 657. That legislation also removes the requirement for the Authority to adopt a procedure for allocating the aggregate tax credit limit by rule.

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 beyond that of the relevant divisions of 2025 Iowa Acts, Senate File 657.

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 January 15, 2026. 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:

January 13, 2026 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
January 15, 2026 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

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 57**.

ITEM 2. Rescind and reserve **261—Chapter 66**.

ITEM 3. Rescind and reserve **261—Chapter 76**.

ARC 9832C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to redevelopment tax credits program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 65, "Brownfield and Grayfield Redevelopment," and adopt a new Chapter 65, "Redevelopment Tax Credits Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 15.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 65 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Redevelopment Tax Credits Program available pursuant to Iowa Code chapter 15, subchapter II, part 9, as amended by 2025 Iowa Acts, Senate File 657 and House File 975. The program provides tax credits for the acquisition, remediation, or redevelopment of brownfield and grayfield sites.

The new chapter is clearer and more concise throughout and omits language that duplicates statute. The new chapter omits language that is unnecessary due to the repeal of the Brownfield Redevelopment Program and the elimination of the Brownfield Advisory Council by 2025 Iowa Acts, House File 975. The new chapter also incorporates the Certified Public Accountant (CPA) attestation added to the Redevelopment Tax Credits Program in House File 975. Inconsistencies with statute amended by 2025 Iowa Acts, Senate File 657, have also been addressed.

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 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 January 15, 2026. 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:

January 13, 2026 9:30 to 9:45 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
January 15, 2026 9:30 to 9:45 a.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 65 and adopt the following **new** chapter in lieu thereof:

CHAPTER 65
REDEVELOPMENT TAX CREDITS PROGRAM

261—65.1(15) Definitions. As used in this chapter unless the context otherwise requires:

"Acquisition" means the purchase of brownfield or grayfield property.

"Affiliate" or *"affiliated entity"* means any entity to which one or more of the following applies:

1. The entity directly, indirectly, or constructively controls another entity.
2. The entity is directly, indirectly, or constructively controlled by another entity.
3. The entity is subject to the control of a common entity. A common entity is one that owns directly or individually more than 10 percent of the voting securities of the entity.

"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.

"Brownfield site" means the same as defined in Iowa Code section 15.291.

"Grayfield site" means the same as defined in Iowa Code section 15.291.

"Previously remediated or redeveloped site" means a site at which prior remediation or redevelopment has occurred, including development for which an award of tax credits under this chapter has been made, and identified by the authority pursuant to the criteria in subrule 65.2(2).

"Program" means the redevelopment tax credits program administered pursuant to Iowa Code chapter 15, subchapter II, part 9, and this chapter.

"Qualifying investment" means the same as defined in Iowa Code section 15.291.

"Qualifying investor" means an applicant who has been approved by the authority to receive a redevelopment tax credit.

"Qualifying redevelopment project" means the same as defined in Iowa Code section 15.291.

"Redevelopment" means construction or development activities associated with a qualifying redevelopment project that are undertaken either for the purpose of constructing new buildings or improvements at a site where formerly existing buildings have been demolished or for the purpose of rehabilitating, reusing, or repurposing existing buildings or improvements. Redevelopment typically includes projects that result in the elimination of blighting characteristics as defined by Iowa Code section 403.2.

"Remediation" includes characterization, risk assessment, removal, and cleanup of environmental contaminants located on and adjacent to a brownfield site in compliance with appropriate Iowa department of natural resources requirements and guidelines.

261—65.2(15) Eligibility. To be eligible for the program, an applicant must meet the criteria for eligibility in Iowa Code chapter 15, subchapter II, part 17 as amended by 2025 Iowa Acts, Senate File 657, and this rule.

65.2(1) *Site control.* The applicant must own the brownfield site or grayfield site or the applicant must have an agreement with the owner of a brownfield site or grayfield site prior to applying for tax credits. The agreement will include:

a. The total cost for remediating the site.

b. That the owner shall transfer title of the property to the applicant upon completion of the remediation of the property. Title transfer is not required when the applicant is the owner of the property and no title transfer occurs.

c. That upon the subsequent sale of the property by the applicant to a person other than the original owner, the original owner shall receive not more than 75 percent of the estimated total cost of the remediation, acquisition, or redevelopment.

65.2(2) *Previously remediated or redeveloped sites.* The authority will determine whether a project constitutes subsequent redevelopment at the same site as a previously remediated or redeveloped site by considering factors including but not limited to:

a. Whether the redevelopment described in multiple proposed projects is planned for a single parcel.

b. Whether the redevelopment described in multiple proposed projects is planned for adjacent or contiguous parcels or parcels in very close physical proximity.

c. Whether all involved parcels are owned by the same entity, different entities, or affiliated entities.

d. Whether a proposed project is the result of the same planning process as another project.

e. Whether the proposed projects are being developed by the same entity, different entities, or affiliated entities.

f. Whether the development of one proposed project occurs at or near the same time as another proposed project.

65.2(3) *Leaking underground storage tanks.* A project that includes remediation of contaminants being addressed under Iowa's leaking underground storage tank (UST) program is not eligible for the program unless other nonpetroleum contaminants or petroleum substances not addressed under 567—Chapter 135 are present.

65.2(4) *Violations of law.* The authority will determine whether the applicant has a record of violations of law that over a period of time tends to show a consistent pattern or that establishes intentional, criminal, or reckless conduct in violation of such laws. An applicant with such a record of violations of the law shall be ineligible for the program.

261—65.3(15) Limitations on qualifying investment. For the purposes of identifying qualifying investment for the purposes of the program, the following shall not be included:

1. The portion of the total cost of a project that is financed by federal, state, or local government tax credits, grants, forgivable loans, or other forms of financial assistance that do not require repayment, excluding the tax incentives provided under the program.
2. Any costs, including acquisition costs, incurred before the project is approved by the board.
3. Building permits, building inspection fees, furnishings, appliances, accounting services, legal services, loan origination and other financing costs including interest on construction loans, syndication fees, and related costs; developer fees; or the costs associated with selling or renting the property whether incurred before or after completion of the project.

261—65.4(15) Application—registration of projects—agreements.

65.4(1) *Application.*

a. Applications for redevelopment tax credits will only be accepted during the annual application period established by the authority.

b. An investor applying for a tax credit shall provide the authority with all of the following:

(1) The total costs of the qualifying redevelopment project, including the costs of land acquisition, cleanup, and redevelopment.

(2) The financing sources of the investment that are directly related to the qualifying redevelopment project for which the investor is seeking approval for a tax credit as provided in this chapter.

(3) Any other information deemed necessary to review and score the application pursuant to this rule.

65.4(2) *Scoring.* Each complete and eligible application will be reviewed and scored by the authority pursuant to Iowa Code section 15.293B(1)*"f"* as amended by 2025 Iowa Acts, House File 975. Review criteria may include but are not limited to project need, project readiness, financial capacity, and project impact.

65.4(3) *Registration.* The authority will make tax credit award recommendations and register projects pursuant to Iowa Code section 15.293B(1)*"e"* as amended by 2025 Iowa Acts, House File 975.

65.4(4) *Approval.* Tax credit awards and amounts of tax credit awards are subject to approval by the board pursuant to Iowa Code section 15.293B(1)*"e"* as amended by 2025 Iowa Acts, House File 975. Awards may be conditioned upon commitment of other sources of funds necessary to complete the activity.

65.4(5) *Agreement.*

a. The agreement entered pursuant to Iowa Code section 15.293B(3) will identify the tax credit amount, the award date, the project completion deadline, the qualifying investment and the total costs of the project.

b. The qualifying investor must execute and return the agreement to the authority within 90 days of transmittal of the final agreement from the authority. Failure to do so may be cause for the board to terminate the award.

c. Agreement amendments must comply with Iowa Code chapter 15, subchapter II, part 9 as amended by 2025 Iowa Acts, Senate File 657, and this chapter. Qualifying investors may submit requests for amendments to authority staff.

(1) Except as provided in paragraph 65.4(4)*"b,"* requests to amend an agreement must be approved by the board.

(2) The board may designate authority staff with authority to approve nonsubstantive changes, including but not limited to the following:

1. Recipient name, address, and similar changes.
2. Line-item budget changes that do not reduce overall total project costs or qualifying investment.
3. Extension of a project completion deadline of up to 12 months.

d. Noncompliance with the agreement may result in revocation of all or a portion of the tax credit award pursuant to Iowa Code section 15.293B(3).

65.4(6) *Reports.* Qualifying investors shall submit any information reasonably requested by the authority in sufficient detail to permit the authority to prepare any reports required by the authority, the board, the general assembly, or the governor's office.

65.4(7) *Project completion.* The project completion deadline may be extended pursuant to Iowa Code section 15.293B(4). The authority may for good cause within the discretion of the authority extend a qualifying investor's completion deadline by up to 12 months upon application by the qualifying investor, which application shall be made prior to the expiration of the completion deadline in the manner and form prescribed by the authority. The authority may approve a second extension of up to 12 months if, prior to the expiration of the first 12-month extension, the qualifying investor applies and substantiates to the satisfaction of the authority that the second extension is warranted due to extenuating circumstances outside the control of qualifying investor.

65.4(8) *Certified public accountant (CPA) examination.* The attestation applicable to the examination required pursuant to Iowa Code section 15.293B(5) as amended by 2025 Iowa Acts, House File 975, is SSAE No. 10 (as amended by SSAE Nos. 11, 12, 14), AT section 101 and AT section 601 or other comparable attestations identified by the authority. The procedures used by the CPA to conduct the examination should allow the CPA to conclude that, in the CPA's professional judgment, the expenditures claimed are eligible pursuant to the agreement; Iowa Code chapter 15, subchapter II, part 9; and all rules adopted pursuant to Iowa Code chapter 15, subchapter II, part 9, in all material respects. Within ten business days of a request by the authority, the qualifying investor shall make available to the authority the documents reviewed by the CPA unless good cause is shown.

261—65.5(15) Redevelopment tax credit.

65.5(1) *Tax credit certificate.*

a. Issuance. The authority may issue a redevelopment tax credit certificate upon completion of the project and submittal of proof of completion by the qualifying investor, including the CPA attestation required pursuant to Iowa Code section 15.293B(5) as amended by 2025 Iowa Acts, House File 975, and as described in subrule 65.4(8).

b. Claims. To claim a tax credit under this rule, a qualifying investor shall file a claim with the department of revenue pursuant to the applicable rules adopted by the department of revenue. A tax credit certificate shall not be used or included with a return filed for a taxable year beginning prior to the tax year listed on the certificate. The tax credit certificate(s) included with the qualifying investor's tax return shall be issued in the qualifying investor's name, expire on or after the last day of the taxable

year for which the qualifying investor is claiming the tax credit, and show a tax credit amount equal to or greater than the tax credit claimed on the qualifying investor's tax return.

c. Transfer. Tax credit certificates issued under this rule may be transferred to any person or entity to the extent allowed by Iowa Code section 15.293A(2)*"d"* and any applicable rules adopted by the department of revenue.

65.5(2) *Tax credit amount and limitations.*

a. The amount of the tax credit shall equal the applicable percentage of the qualifying investor's qualifying investment specified in Iowa Code section 15.293A(3).

b. The maximum amount of tax credits the board may award in any one fiscal year is specified in Iowa Code section 15.293A(6) as amended by 2025 Iowa Acts, Senate File 657.

65.5(3) *Tax credit carryover.* If the maximum amount of tax credits available has not been issued at the end of the fiscal year, the remaining tax credit amount may be carried over to a subsequent fiscal year or the authority may prorate the remaining credit amount among other eligible applicants.

These rules are intended to implement Iowa Code chapter 15, subchapter II, part 9 as amended by 2025 Iowa Acts, Senate File 657 and House File 975.

ARC 9828C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to research and development tax credit program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to adopt a new Chapter 82, "Research and Development Tax Credit Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 15.106A and 15.523.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15, subchapter II, part 35.

Purpose and Summary

The Authority proposes to adopt a new Chapter 82 to describe the policies and procedures applicable to the Research and Development Tax Credit Program, created pursuant to Iowa Code chapter 15, subchapter II, part 35, as enacted by 2025 Iowa Acts, Senate File 657. The program provides incentives to businesses that conduct qualified research and development in Iowa.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 15, 2025. A public hearing was held on the following date(s):

- November 4, 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 January 13, 2026. 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 82:

CHAPTER 82
RESEARCH AND DEVELOPMENT TAX CREDIT PROGRAM

261—82.1(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.

"Director" means the director of the authority.

"Eligible expenditures" means the same as defined in Iowa Code section 15.521 as enacted by 2025 Iowa Acts, Senate File 657.

"Foreign adversary" means a foreign government or foreign non-government person as determined in 15 CFR §7.4 or 15 CFR §791.4 at any time on or after March 4, 2024, and that is listed in 15 CFR §7.4(a) or 15 CFR §791.4(a) at any time on or after March 4, 2024.

"Foreign adversary entity" means a foreign business subject to the jurisdiction of or organized under the laws of a foreign adversary or a foreign business owned, directed, or controlled by a foreign adversary.

"Foreign business" means the same as defined in Iowa Code section 9I.1.

"Independent certified public accountant" or *"independent CPA"* means a certified public accountant not employed by the qualified business or a related entity.

"Program" means the research and development tax credit program administered pursuant to this chapter and Iowa Code chapter 15, subchapter II, part 35 as enacted by 2025 Iowa Acts, Senate File 657.

"Qualified business" means the same as defined in Iowa Code section 15.521 as enacted by 2025 Iowa Acts, Senate File 657.

"Qualified research and development" means the same as defined in Iowa Code section 15.521 as enacted by 2025 Iowa Acts, Senate File 657.

261—82.2(15E) Certification of qualified businesses.

82.2(1) *Eligibility for certification as a qualified business.* A business shall meet all of the criteria in Iowa Code section 15.522 as enacted by 2025 Iowa Acts, Senate File 657, to be eligible for certification as a qualified business. Additionally, a foreign business shall demonstrate that it is not associated with a foreign adversary or foreign adversary entity.

82.2(2) *Additional sectors.* Any individual or business may request in writing that the authority include an additional sector(s) to the list of sectors available for the credit pursuant to Iowa Code section 15.522(2) as enacted by 2025 Iowa Acts, Senate File 657. The authority may initiate the administrative rulemaking process to include an additional sector or sectors in response to such a request or on its own initiative. A business engaged in a sector included by rule pursuant to this subrule shall not apply for certification as a qualified business until after the effective date of the rulemaking to include that sector.

82.2(3) *Application for certification.* A qualified business shall apply to the authority for certification as a qualified business as prescribed by the authority. An applicant shall apply on behalf of all entities in a consolidated group for state or federal tax filing purposes. 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 Iowa business locations, and whether the business conducts research and development at any locations outside Iowa.

c. Information that demonstrates that the business's primary operations are in a qualified industry and sector pursuant to Iowa Code section 15.522 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 and sectors 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 and sector identified in Iowa Code section 15.522 as enacted by 2025 Iowa Acts, Senate File 657, based on factors including but not limited to sources of revenue and customer base.

d. Information that demonstrates that the business is actively engaged in qualified research and development in Iowa.

e. Information about employment of the qualified business.

f. The identity of any entities included as part of a controlled group/group of trades or businesses under common control that is required to compute the federal research and development credit as one taxpayer pursuant to Section 41(f)(1) of the Internal Revenue Code.

g. A signed statement from an officer, director, manager, member, or general partner of the qualified business certifying the accuracy of the information provided.

h. Any other information or documentation as the authority may reasonably require to determine the business's eligibility for certification as a qualified business and whether research and development conducted by the business is qualified research and development.

82.2(4) *Authority review and notice of certification.*

a. The authority shall make its best efforts to determine whether a business will be certified as a qualified business within 90 days of receipt of all information and documentation necessary to demonstrate satisfaction of the criteria set forth in Iowa Code section 15.522 as enacted by 2025 Iowa Acts, Senate File 657. The authority may conduct site visits to assess the eligibility of the business and the research conducted by the business.

b. The authority will determine whether an applicant for certification has a record of violations of the law that over a period of time tends to show a consistent pattern or that establishes intentional,

criminal, or reckless conduct in violation of such laws. An applicant that has such a record of violations of the law will be ineligible for certification.

c. Authority staff will make recommendations for approval or denial of applications for certification. The director may approve, deny, or defer an application for certification.

d. Approval of certification by the director shall be contingent upon execution of an agreement with the authority within 45 days of transmittal of the agreement. The time limit for execution may be extended by the director for an additional 45 days for good cause shown. Upon expiration of the time limit, including any extension, approval of certification of a qualified business shall be rescinded.

e. Following execution of an agreement pursuant to paragraph 82.2(4)*"d,"* the authority will issue written notice to the qualified business that such business has been certified with the authority for the purpose of the program. The authority will indicate in its written notice the first tax year for which eligible expenditures may be eligible for a tax credit.

82.2(5) *Revocation and expiration of certification.*

a. A certified qualified business shall provide any information as the authority may reasonably request to confirm the business's continued eligibility for certification as a qualified business and whether the business continues to be actively engaged in qualified research and development.

b. If a qualified business fails to meet or maintain any requirement set forth in the agreement entered pursuant to Iowa Code section 15.523(3) as enacted by 2025 Iowa Acts, Senate File 657; this chapter; or Iowa Code chapter 15, subchapter II, part 35 as enacted by 2025 Iowa Acts, Senate File 657, the authority may suspend or revoke the business's certification as a qualified business by issuing written notice to the business. The notice will identify the last date on which the business was eligible to be certified as a qualified business. If certification is revoked, the notice will identify the first date on which the business will be eligible to reapply for certification. If certification is suspended, the notice will identify the proposed end date of the suspension. A business cannot apply for a tax credit for eligible expenditures incurred after the effective date of revocation or during the effective period of suspension.

c. The written notice of certification issued pursuant to paragraph 82.2(4)*"e"* will include the date the authority expects the certification to expire if a business continues to satisfy all eligibility requirements. Certification may expire up to five years from the date of the notice. If a determination cannot be made that the qualified business intends to engage in qualified research and development for five years, the authority may approve certification for less than five years.

d. A business may submit an application for recertification and be approved for recertification by the authority.

e. If a business's certification as a qualified business expires, expenditures made after the expiration date will not be eligible for a tax credit.

82.2(6) *Reporting.* The authority may, at any time, request additional information and documentation from a qualified business to meet the authority's reporting obligations pursuant to Iowa Code section 15.525 as enacted by 2025 Iowa Acts, Senate File 657, or required to prepare any other reports to be provided to the governor and the general assembly.

261—82.3(15E) Application and review process for tax credits.

82.3(1) *Annual business application.* A qualified business shall make its best efforts to submit its annual application for a tax credit no later than 90 days after the date its federal return is filed and accepted. The application shall be submitted no later than January 31 following the most recently filed and accepted federal tax return. A qualified business shall apply for tax credits on behalf of all entities in a consolidated group for state or federal tax filing purposes and include all application information for all such entities that incurred eligible expenditures. The annual application submitted by qualified businesses will include:

a. A report from the business of any changes to the information provided in the application for certification pursuant to subrule 82.2(3).

b. Documentation of the amount of the eligible expenditures that were included in Section F of Internal Revenue Form 6765 that was submitted with the qualified business's most recently filed and accepted federal tax return.

c. Verification of eligible expenditures by an independent CPA authorized to practice in this state, described on a form prescribed by authority.

(1) The procedures used by the independent CPA to conduct the verification should allow the independent CPA to conclude that, in the independent CPA's professional judgment, the expenditures claimed are eligible pursuant to the agreement entered pursuant to Iowa Code section 15.523(3) as enacted by 2025 Iowa Acts, Senate File 657; Iowa Code chapter 15, subchapter II, part 35 as enacted by 2025 Iowa Acts, Senate File 657; and all rules adopted pursuant to Iowa Code chapter 15, subchapter II, part 35, and 2025 Iowa Acts, Senate File 657, in all material respects. The verification shall include but not be limited to the following:

1. The qualified business continues to meet all industry and sector requirements in Iowa Code section 15.522 as enacted by 2025 Iowa Acts, Senate File 657.

2. The qualified research and development and eligible expenditures are supported by the qualified business's underlying books and records.

3. The qualified business claimed a federal research credit under Section 41 of the Internal Revenue Code for its eligible expenditures for the same tax year for which the business has applied for a tax credit under the program.

4. The qualified business's methodology for identifying eligible expenditures accurately identifies qualified research and development projects and activities and accurately calculates qualified research expenses under Section 41 of the Internal Revenue Code that occurred in Iowa.

5. The wages included as eligible expenditures are limited to wages paid for the performance, direct supervision, or direct support of qualified research and development, and such services were physically performed in Iowa by individuals legally authorized to work in Iowa.

6. Any amounts included as eligible expenditures that were paid to unrelated third parties were for qualified research and development performed on behalf of the qualified business, and the qualified business retained substantial rights in the results and bore the financial risk of failure of the qualified research and development performed by a third party.

7. Any amounts included as eligible expenditures that were paid to unrelated third parties were for qualified research and development physically performed in Iowa by individuals authorized to work in Iowa.

8. Only 65 percent of eligible contract research expenses were included as eligible expenditures.

9. Only nondepreciable tangible property used directly in the conduct of qualified research and development was included as eligible expenditures.

10. Only supplies used or consumed in Iowa in the conduct of qualified research and development were included as eligible expenditures.

11. Only rental or lease costs for computers or cloud computing resources used in qualified research were included as eligible expenditures, and such resources were operated by third-party providers and not primarily used by the qualified business.

12. Amounts included as eligible expenditures relate only to computers physically located in Iowa, or, for cloud computing resources, an allocation methodology reasonably attributes usage to Iowa-based qualified research and development activities.

13. Expenditures were captured and allocated to qualified research and development activities at the business component or project level.

14. The qualified research and development activities associated with eligible expenditures met all four statutory tests under Section 41(d) of the Internal Revenue Code: permitted purpose, elimination of uncertainty, process of experimentation, and technological in nature.

15. No expenditures were included for research to the extent funded by another person, grant, or governmental entity.

(2) For each item in subparagraph 82.3(1)*"c"*(1), the independent CPA shall describe the information and documentation relied upon to verify each item.

(3) The independent CPA shall certify that the verification procedures were performed in accordance with professional standards and, to the best of the independent CPA's knowledge, the information provided is accurate and complete.

(4) Within ten business days of a request by the authority, the qualified business shall make available to the authority the documents reviewed by the independent CPA unless good cause is shown.

d. A signed statement from an officer, director, manager, member, or general partner of the qualified business certifying the accuracy of the information provided.

e. Any other information as the authority may reasonably require to determine the business's continued eligibility for certification as a qualified business and whether the business continues to be actively engaged in qualified research and development.

82.3(2) *Staff review.* Authority staff will verify the continued eligibility of qualified businesses and the amount of eligible expenditures incurred by qualified businesses prior to approval of tax credits by the director.

82.3(3) *Tax credit calculation.* The annual tax credit award for each qualified business shall equal its unadjusted credit or its adjusted credit, whichever is less.

a. Unadjusted credit. The unadjusted credit for a qualified business equals its eligible expenditures multiplied by the tax credit rate provided in the agreement, not to exceed 3.5 percent.

b. Adjusted credit. To calculate the adjusted credit for a qualified business, first divide the qualified business's eligible expenditures by the total eligible expenditures incurred by all qualified businesses with approved tax credit applications for the fiscal year. Next, multiply that quotient by the amount of tax credits available pursuant to Iowa Code section 15.119 for the fiscal year after reduction for the set aside, if any, of tax credits for additional awards pursuant to subrule 82.3(4). That product, plus any additional tax credits awarded to the qualified business for the fiscal year pursuant to subrule 82.3(4), equals a qualified business's adjusted credit.

EXAMPLE: For purposes of this example, assume that the total available tax credits for the fiscal year is $40,000,000 and the authority does not set aside any of that amount for additional awards pursuant to subrule 82.3(4). Also assume that the total eligible expenditures incurred by all qualified businesses with approved tax credit applications for the fiscal year is $2,000,000,000. A qualified business submits an annual tax credit application with $10,000,000 of eligible expenditures, and the tax credit rate in its agreement is 3.5 percent. The qualified business's unadjusted credit equals $350,000 ($10,000,000 × 0.035). The qualified business's adjusted credit equals $200,000 (($10,000,000 / $2,000,000,000) × $40,000,000). Therefore, the qualified business's annual tax credit award will be $200,000.

82.3(4) *Set aside of tax credits for additional awards.* The authority may set aside up to 5 percent of the amount of tax credits available pursuant to Iowa Code section 15.119 for the fiscal year to be awarded as additional tax credits to qualified businesses that demonstrate an increase in eligible expenditures.

a. Additional tax credits from the set aside described in this subrule may be awarded based on the annual applications submitted by qualified businesses pursuant to subrule 82.3(1). The authority may request additional information from qualified businesses to establish that a qualified business demonstrates an increase in eligible expenditures and that additional tax credits are warranted pursuant to the factors in paragraph 82.3(4)*"c."*

b. Each fiscal year, the authority will determine the total amount of the set aside, if any, prior to making an initial apportionment of tax credits based on the total amount of qualified expenditures incurred by all qualified businesses that are eligible for a tax credit.

c. Factors the authority will consider in determining whether to award additional tax credits to a qualified business include but are not limited to whether the qualified business recently located in or expanded in Iowa and the economic impact of the qualified business, its facility or facilities in Iowa, and the qualified research and development.

82.3(5) *Application decisions.* The director may approve, deny, or defer an application for tax credits. Applications for tax credits may be denied under the following circumstances:

a. The qualified business has not continued to engage in the qualified research and development proposed in its application for certification.

b. The qualified business experiences a business closure or experiences a mass layoff for which notice is required under Iowa Code chapter 84C.

c. The authority determines the qualified business has a record of violations of the law that over a period of time tends to show a consistent pattern or that establishes intentional, criminal, or reckless conduct in violation of such laws.

261—82.4(15E) Tax credit certificates.

82.4(1) *Issuance by the authority.* The authority will issue tax credit certificates to qualified businesses pursuant to Iowa Code section 15.524 as enacted by 2025 Iowa Acts, Senate File 657. Tax credit certificates will be issued to the qualified businesses that applied for certification.

82.4(2) *Vested right.* A taxpayer does not obtain a vested right in a tax credit until a certificate has been issued by the authority.

82.4(3) *Claiming a 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.

82.4(4) *Changes to federal credit.*

a. The qualified business shall notify the authority of any reduction of the federal credit for increasing research activities under Section 41 of the Internal Revenue Code or reduction of qualified research expenditures for the federal credit that occurs after certification as a qualified business. Such notice is required whether the reduction is the result of review of the credit initiated by the Internal Revenue Service or an amendment to the qualified business's tax return initiated by the qualified business. The qualified business must provide notice to the authority within 30 days of the final determination date as defined in Iowa Code section 422.25.

b. Following a report to the authority that the federal credit or qualified research expenditures for the purposes of the federal credit have been reduced, a qualified business must submit a supplemental verification of eligible expenditures by an independent CPA authorized to practice in this state conducted in accordance with the procedures identified in subrule 82.3(1). The supplemental verification shall detail the impact of the disallowed credit on the amount of eligible expenditures, if any. The authority may waive the requirement to submit supplemental verification if all qualified expenditures on which the federal credit was claimed occurred in Iowa, if the qualified business agrees to a reduced tax credit consistent with a reduction in qualified research expenditures as determined by the authority, or if sufficient information is otherwise available to determine the impact on the tax credit available through the program.

c. If the supplemental independent CPA verification or other information submitted pursuant to paragraph 82.4(4)*"b"* demonstrates a reduction in eligible expenditures, the tax credit available through the program shall be reduced to an amount calculated by multiplying the credit percentage determined pursuant to subrule 82.3(3) by the reduced amount of eligible expenditures. Any additional award pursuant to subrule 82.3(4) will be reduced in the same way. If sufficient information is not available to determine the reduced amount of eligible expenditures, the authority may wholly rescind a tax credit available under the program.

d. The tax credit available through the program shall not be increased based on an increase in the federal credit for increasing research activities under Section 41 of the Internal Revenue Code claimed by a qualified business.

261—82.5(15) Mass layoffs and business closures.

82.5(1) Pursuant to Iowa Code section 15.112 as enacted by 2025 Iowa Acts, Senate File 657, the authority may reduce or eliminate some or all of a tax credit approved through the program under the following circumstances:

a. A qualified business closes a facility in Iowa.

b. A qualified business experiences a mass layoff for which notice is required under Iowa Code chapter 84C that directly impacts its qualified research and development conducted in Iowa.

c. A qualified business experiences a mass layoff for which notice is required under Iowa Code chapter 84C that represents a significant portion of the qualified business's employees in Iowa.

82.5(2) The authority may deny certification or recertification of a qualified business under the circumstances identified in subrule 82.5(1).

82.5(3) Factors the authority may consider when determining whether to exercise its discretion under this rule include but are not limited to the percentage of the qualified business's workforce affected; the total number of employees involved; whether the action is seasonal, temporary, or permanent; whether employees are relocated to other Iowa facilities; the reasons causing the mass layoff or business closure; and the impact on the qualified business's qualified research and development conducted in Iowa, the community in which the mass layoff or business closure occurred, and the state.

261—82.6(7C) References. All references to the Internal Revenue Code in this chapter are as in effect on [effective date of this rulemaking].

These rules are intended to implement Iowa Code chapter 15, subchapter II, part 35 as enacted by 2025 Iowa Acts, Senate File 657.

ARC 9831C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to small business innovation research and technology transfer outreach program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 106, "Small Business Innovation Research and Technology Transfer Outreach Program," and to adopt a new Chapter 106, "Small Business Innovation Research and Technology Transfer Outreach Program America's Seed Fund," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 15.106A and 15.411(5).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 15.411(3).

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 106 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Small Business Innovation Research and Technology Transfer Outreach Program, known as America's Seed Fund, established pursuant to Iowa Code section 15.411. The program provides technical and financial assistance for applicants for federal grant and contract awards. The updated chapter will be clearer and more concise throughout and will omit language that repeats statutory language. Current policies for the disbursement of funds will be incorporated in the new chapter.

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

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 January 15, 2026. 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:

January 13, 2026 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
January 15, 2026 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

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 106 and adopt the following **new** chapter in lieu thereof:

CHAPTER 106
SMALL BUSINESS INNOVATION RESEARCH AND TECHNOLOGY TRANSFER OUTREACH PROGRAM (AMERICA'S SEED FUND)

261—106.1(15) Definitions. As used in this chapter unless the context otherwise requires:

"Applicant" means a business applying to the authority for assistance under the program.

"Assistance" means technical and financial assistance available under the program.

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

"Award" means SBIR/STTR grant or contract funds awarded by federal agencies.

"Board" means the same as defined in Iowa Code section 15.102.

"Committee" means the technology commercialization committee established by the board pursuant to Iowa Code section 15.116.

"Corporation" means the bioscience development corporation established pursuant to Iowa Code section 15.107.

"Eligible applicant" means a business meeting the criteria in rule 261—106.2(15).

"Financial assistance" means assistance provided only from the funds, rights, and assets legally available to the authority and includes but is not limited to assistance in the form of grants, loans, forgivable loans, and royalty agreements.

"Innovative business" means the same as defined in Iowa Code section 15E.52(1)*"c."*

"Phase II award" means an award that provides funding to continue research and development funded with a prior award.

"Program" means the small business innovation research and technology transfer outreach program established pursuant to Iowa Code section 15.411 and this chapter.

"SBIR/STTR" means the federal Small Business Innovation Research and Small Business Technology Transfer Programs known as America's seed fund.

261—106.2(15) Eligibility requirements. To be eligible for the program, an applicant must meet the following requirements:

1. Meet the small business requirements defined by the federal Small Business Administration (SBA).
2. Be an innovative business;
3. Have a reasonable likelihood of receiving an award;
4. Be likely to stimulate subsequent investment by industry, venture capital, and other sources; and
5. Be likely to commercialize promising technology.

261—106.3(15) Program benefits, application procedures, and delegation of functions.

106.3(1) *Technical assistance.*

a. Technical assistance provided by the authority under the program may include the following:

(1) Detailed outlines and other tools to facilitate drafting of a proposal and gathering accompanying documentation.

(2) Reviews and critiques of proposal drafts.

(3) Evaluation of budgets and budget justifications.

(4) Assistance with the electronic registrations and the application submission process.

b. To facilitate technical assistance, applicants shall submit pre-proposal documents to the authority that demonstrate a customized strategy for application for an award consistent with the requirements for the relevant rules and regulations of each applicable federal agency.

106.3(2) *Application for financial assistance and award procedures.* Eligible applicants may submit applications to the authority for financial assistance. Authority staff will confirm program eligibility before forwarding an application to the committee for a recommendation on financial assistance. The committee will provide its recommendation to the board. The board may approve, deny, or defer each application for financial assistance. The board will consider applications for financial assistance on a first-come, first-served basis. The board may award up to $75,000 in financial assistance, to be disbursed as indicated in subrule 106.4(3).

106.3(3) *Delegation of certain administrative functions to the corporation.* The authority may delegate certain administrative functions of the program to the corporation.

106.3(4) *Administrative functions not delegated.* The authority will retain, and not delegate, the performance of the following functions:

a. The final determination as to whether to approve, deny, or defer an award of financial assistance;

b. The disbursal of moneys provided for in an award of financial assistance; and

c. The final determination as to whether there is a default in the terms of an agreement entered into under the program, including all decisions regarding appropriate remedies for such a default.

261—106.4(15) Agreement and report information required.

106.4(1) *Agreement required.* An applicant awarded financial assistance under the program shall enter into an agreement with the authority that includes all terms and conditions for receipt of funds. The authority will make the final determination as to compliance with the terms of the agreement and as to whether and when to disburse funds to the applicant.

106.4(2) *Reporting information required.* An applicant may be required to submit all information necessary for the authority to compile a report on the results of the program.

106.4(3) *Disbursement.* Up to $50,000 in financial assistance may be disbursed to an eligible applicant upon receipt of an award. Up to $25,000 in financial assistance may be disbursed to an eligible applicant at the time the eligible applicant submits a proposal for a phase II award.

These rules are intended to implement Iowa Code section 15.411.

ARC 9833C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to reinvestment districts program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 200, "Reinvestment Districts Program," Iowa Administrative Code, and to adopt a new Chapter 200 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 15J and section 15.106A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15J.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 200 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Reinvestment Districts Program administered by the Authority pursuant to Iowa Code chapter 15J. The program enables new State hotel/motel and sales tax revenues to be reinvested within approved districts.

The updated chapter will be more concise throughout. Unnecessary definitions, language that duplicates statute, and language that is redundant within the chapter will be eliminated. Specific point totals for scoring criteria will also be removed from the chapter.

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 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 January 15, 2026. 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:

January 13, 2026 9:45 to 10 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
January 15, 2026 9:45 to 10 a.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 200 and adopt the following **new** chapter in lieu thereof:

CHAPTER 200
REINVESTMENT DISTRICTS PROGRAM

261—200.1(15J) Definitions. For purposes of this chapter unless the context otherwise requires:

"Account" means the district account that is created within the fund for each municipality that has established a district and that holds the new tax revenues deposited by the department under the program.

"Applicant" means a municipality applying to the board and the authority for approval of a district under the program, including the preapplication process described in rule 261—200.2(15J).

"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.

"Commencement date" means the same as defined in Iowa Code section 15J.2.

"Department" means the department of revenue.

"District" means the same as defined in Iowa Code section 15J.2.

"Due diligence committee" means the due diligence committee of the board established pursuant to 261—Chapter 1.

"Fund" means the same as defined in Iowa Code section 15J.2.

"Joint board" means a legal entity established or designated in an agreement made pursuant to Iowa Code chapter 28E between two or more contiguous counties or incorporated cities.

"Maximum benefit amount" means the total amount of new tax revenues that may be remitted to a municipality's account and used for development in a district. The maximum benefit will be established by the board when a final application to the program is approved pursuant to rule 261—200.5(15J).

"Municipality" means the same as defined in Iowa Code section 15J.2.

"New lessor" means the same as defined in Iowa Code section 15J.2.

"New retail establishment" means the same as defined in Iowa Code section 15J.2.

"New tax revenues" means all state sales tax revenues and state hotel and motel tax revenues that are collected within a district by new retail establishments and new lessors, provided that such new retail establishments and lessors are included as projects in an approved district plan. New tax revenues are remitted to the department after collection by new retail establishments and new lessors and deposited by the department in an account.

"Program" means the reinvestment district program established pursuant to Iowa Code chapter 15J as amended by 2025 Iowa Acts, House File 975, and this chapter.

"Project" means the same as defined in Iowa Code section 15J.2.

"Retail business" means any business engaged in the business of selling tangible personal property or taxable services at retail in this state that is obligated to collect state sales or use tax under Iowa Code chapter 423. However, for the purposes of this chapter, "retail business" does not include a new lessor or a business engaged in an activity subject to tax under Iowa Code section 423.2(3).

"State hotel and motel tax" means the same as defined in Iowa Code section 15J.2.

"State sales tax" means the same as defined in Iowa Code section 15J.2.

"Substantially improved" means the same as defined in Iowa Code section 15J.2.

"Unique nature" means a quality or qualities of the projects to be developed in a district that, when considered in the entirety, will substantially distinguish the district's projects from other existing or proposed developments in the state. For purposes of this chapter, whether a project is of a unique nature is a subjective and contextual determination that will be made by the board. In determining whether a project is of a unique nature, the board will not necessarily require a project to be entirely without precedent or to be the only one of its kind in the state, but rather, the board will evaluate whether the projects to be undertaken in a district will either (1) permanently transform the aesthetics or infrastructure of a local community for the better, including by preserving important historical structures or neighborhoods, or (2) contribute substantially more to the state's economy or quality of life than other similar projects in the state.

"Vertical improvement" means the same as defined in Iowa Code section 15J.2. For the purposes of this definition, "appurtenant structure" means any building or other fixture on a piece of real estate other than the main building, provided that such a building or fixture is permanent, is wholly or partially above grade, and will be constructed or substantially improved in conjunction with the main building. A structure is appurtenant when the structure is physically connected to a main building such that the connected structures combine to create a single, integrated facility. A structure is not physically connected if the structure has a function or purpose independent of the main building, even if the structures are in close proximity or are incidentally connected by some means such as a common wall, a sidewalk, or recreational trail.

261—200.2(15J) Preapplication process.

200.2(1) *Purpose.* The authority and the board will utilize a preapplication process to gauge the level of demand for funding under the program, accept initial project plans and requests for funding, make provisional determinations about the amount of maximum benefits, and notify applicants of the board's provisional funding decisions.

200.2(2) *Preapplication required.* The board will only approve a proposed district plan if that plan has been submitted during the annual filing window as described in this rule.

200.2(3) *Annual filing window.* Each year that funding is available, the authority will announce an annual filing window to accept preapplications under the program. The purpose of the annual filing window is to enable the competitive scoring of applications and facilitate funding decisions by the board that are within the limitations established for the program by the general assembly. A municipality interested in applying to the program must submit a preapplication during the annual filing window or wait until the next annual filing window.

200.2(4) *Preapplication submission requirements.* Each preapplication submission shall demonstrate compliance with the requirements listed in rule 261—200.3(15J) to the greatest extent possible. While the preapplication process is provisional in nature and is designed to allow applicants to make reasonable changes to the proposed district plan before a final application is considered, the board is more likely to approve funding for proposed districts that meet all requirements of rule 261—200.3(15J) during the preapplication process.

200.2(5) *Provisional funding decisions.*

a. The board, with the assistance of the authority, will evaluate the preapplications and assign them a provisional score based on the criteria described in rule 261—200.4(15J). Based on the results of the scoring, the board will make provisional funding decisions and notify applicants.

b. A provisional funding decision represents an initial judgment by the board about the merits of a proposed district plan and is provided for the convenience of both applicants and the board for the better administration of the program. A provisional funding decision shall not be construed as binding on the board nor will the applicant be required to meet all of the details contained in the preapplication. A provisional funding decision shall not be construed as a final approval by the board. A municipality shall not adopt an ordinance or resolution establishing a district based on a provisional funding decision.

c. The final details of a proposed district plan and a final funding decision, including a maximum benefit amount and a commencement date, shall be contingent upon the receipt of a full, final, and complete application and upon final action by the board to ratify, amend, defer, or rescind its provisional funding decision as provided in rule 261—200.5(15J).

d. The department will not deposit moneys into an account until a final application is approved by the board and an ordinance or resolution has been adopted by the municipality.

261—200.3(15J) Program eligibility and application requirements.

200.3(1) *Eligibility.* To be eligible for benefits under the program, an applicant shall demonstrate that all requirements in Iowa Code section 15J.4(1) are met.

a. To establish that the criterion in Iowa Code section 15J.4(1)*"a"* is met, a municipality should submit information such as an estimate of the expected increase in valuation or other data that lends itself to a quantitative assessment of the extent to which the real property will benefit.

b. To establish that the criterion in Iowa Code section 15J.4(1)*"b"* is met, a municipality should submit maps of the proposed area as well as maps of the existing enterprise zone or urban renewal area. A municipality should also submit copies of the local ordinance or resolution establishing the enterprise zone or the urban renewal area.

c. For purposes of establishing that the criterion in Iowa Code section 15J.4(1)*"c"* as amended by 2025 Iowa Acts, House File 975, is met, "contiguous" means parcels that are physically connected. Parcels connected by streets or other rights-of-way will be considered physically connected for purposes of this rule. In designating an area that includes a right-of-way, an applicant may include an area that is less than the full width of the right-of-way, but the applicant shall not include less than 60 feet of the right-of-way's width.

200.3(2) *Proposed district plan.* An applicant must submit a proposed district plan consistent with the requirements of Iowa Code section 15J.4(2) and a copy of the resolution approving the proposed district plan to the authority.

a. The finding required by Iowa Code section 15J.4(2)*"a"* should be supported by the information required under subrule 200.3(1).

b. If, at the time an application is submitted, the parcels to be included in the proposed district are not yet acquired or one or more parcels within the district are under consideration for a project, then the names and addresses of the owners of record of all parcels under consideration shall be submitted with the understanding that final board approval shall be contingent upon all parcels being acquired and identified by address prior to final board approval and establishment of the commencement date.

c. The project description required by Iowa Code section 15J.4(2)*"d"*(4) should include an explanation of why the unique characteristics of the proposed project cause the project to be of a unique nature as defined in rule 261—200.2(15J).

200.3(3) *Additional conditions.* A municipality shall demonstrate to the board's satisfaction that all of the additional conditions in Iowa Code section 15J.4(3)*"b"* are met and the following additional conditions are met:

a. The applicant must have submitted an application under the preapplication process described in rule 261—200.4(15J) and, as part of a provisional funding decision by the board, must have been approved for a provisional maximum benefit amount.

b. The proposed district plan must meet a minimum score under the criteria described in rule 261—200.4(15J).

c. While multiple districts within a single municipality are not prohibited under the program, the size of any one district is limited by Iowa Code section 15J.4(1)*"c"* as amended by 2025 Iowa Acts, House File 975, and overlapping districts are prohibited by Iowa Code section 15J.4(1)*"e."* Therefore, the board will consider whether the approval of an additional district is appropriate given the particulars of the proposed additional district and the goals of the program. If a municipality proposes an additional district, the board, at its discretion, may accept the application and score it, or if the board determines that approval of an additional district would not serve the goals of the program, the board may reject the application without scoring it.

d. While it is within the discretion of the board to increase the maximum benefit amount of an approved district, the board will carefully scrutinize whether an increase is justified by circumstances such as greater investment or improved projects within the district and whether any change in the maximum benefit amount serves the goals of the program.

200.3(4) *Application materials and submission.* A municipality interested in applying for funding under the program shall submit a preapplication and a final application to the board for approval and, when applying, shall provide the information described in this chapter or any other information the board or the authority may reasonably require in order to process the application. Information on submitting an application under the program may be obtained by contacting the authority.

261—200.4(15J) Application scoring and determination of benefits. The board will evaluate and score the proposed district plan submitted with each complete and eligible application according to the criteria and process described in this rule.

200.4(1) *Scoring criteria and plan evaluation.* Each proposed district plan will be given a numerical score between 0 and 100. The higher the numerical score, the more likely the proposed district will be approved for designation and funding under the program. The scoring process will necessarily involve a subjective assessment of the quality of each proposed district plan as well as a consideration of how each proposed district plan compares to the plans proposed by other applicants. The criteria used to score each application are as follows:

a. Uniqueness. The program requires that the projects proposed to be undertaken must be of a unique nature. Therefore, the proposed district plan will be evaluated on this criterion in order to quantify the extent to which the projects in the proposed district plan are of a unique nature. The more unique the projects are, the more points will be received under this criterion.

b. Economic impact. The program requires that the projects proposed to be undertaken must have a substantial beneficial impact on the economy of the state and the economy of the municipality. Therefore, the proposed district plan will be evaluated on this criterion in order to quantify the extent to which the projects in the proposed district plan will benefit the economy. The greater the economic impact of the proposed district plan, the more points will be received under this criterion.

c. Project feasibility. The program requires that funding sources for projects must be feasible. Therefore, the proposed district plan will be evaluated on this criterion in order to quantify the extent to which the funding sources of the proposed projects are feasible. The more feasible the funding sources for the proposed projects are, the more points will be received under this criterion.

d. Capital investment. The program requires that at least one project with a capital investment of $10 million or more be proposed. To the extent that the proposed district plan exceeds this minimum level of capital investment, more points will be received under this criterion.

e. Funding leverage. The program limits the amount of new tax revenues that can be received to 35 percent of the total cost of all proposed projects in the proposed district plan. To the extent that a proposed district plan includes a financing plan in which the percentage of new tax revenues to be received is less than 35 percent of the total cost, more points will be received under this criterion.

f. Nonretail focus. The program limits the amount of proposed capital investment in the district related to retail businesses to 50 percent of the total capital investment for all proposed projects in the proposed district. To the extent that a proposed district plan includes projects that provide cultural amenities, tourist attractions and accommodations, infrastructure, or quality of life improvements, more points will be received under this criterion.

g. Additional factors. The program allows the board to establish additional criteria for the program. Therefore, in addition to the other criteria listed in this subrule, the board will consider the following additional factors:

(1) Readiness for development. The closer a municipality is to beginning development on a proposed district plan, the more points may be received under the additional factors criterion.

(2) Geographic diversity. To the extent that a proposed district is located in a region of the state not already funded under the program, more points may be received under the additional factors criterion. A proposed district plan that would create an additional district within a municipality or a request to increase the maximum benefit amount of an already approved district will not be viewed as enhancing geographic diversity and may receive fewer points under the additional factors criterion.

(3) Funding need. To the extent that a funding gap exists in the proposed district plan's financing, more points may be received under the additional factors criterion.

200.4(2) *Scoring process and funding recommendations.*

a. Proposed district plans will be scored by an evaluation committee consisting of members appointed by the director of the authority. Members of the committee will include authority staff and not more than five members of the board. Each member of the evaluation committee will judge the proposed district plan according to the scoring criteria, and then the scores of all members of the committee will be averaged together to reflect one numerical score between 0 and 100. The evaluation committee will not make a funding recommendation.

b. After all applications are scored, a copy of the proposed district plan and the results of the scoring will be referred to the due diligence committee, which will consider the quality of the proposed district plans and make funding recommendations to the board. The due diligence committee will take into account the requested funding levels but will also attempt to establish maximum benefit amounts that seem most appropriate to both the quality of the proposed district plans and the total demand for program funding.

c. The scoring results will not be negotiated and, while both the board and the due diligence committee will consider the scoring results of the evaluation committee, those results are not binding on either the due diligence committee or the board.

200.4(3) *Minimum score required.* To receive funding under the program, a proposed district plan must receive an average score of 70 or more points under the criteria listed in subrule 200.4(1).

200.4(4) *Funding not guaranteed.* The program is subject to a total aggregate limit on the amount of new tax revenues that may be approved. Therefore, a proposed district plan that meets the required minimum score is not guaranteed funding if the board's funding decisions for other, higher scoring proposed district plans cause the program's total aggregate limit to be reached.

200.4(5) *Final action taken by board.* The final decision on whether to approve the designation of a proposed reinvestment district and the determination of the amount of maximum benefit to award an applicant rest entirely with the board. The recommendations of the evaluation committee and the due diligence committee with respect to the proposed district plans are of an advisory nature only.

200.4(6) *Availability of scoring results.* The board and the authority will keep records of the scoring process and make those records available to applicants.

200.4(7) *Denial of plans and resubmission.* Reasons for denial of district plans may include a failure to meet filing deadlines, a failure to meet the basic requirements for eligibility, a failure to meet the required minimum score, or a lack of available funding. A municipality whose application is denied may resubmit the application at the next annual filing window, provided there is funding available, but a resubmission must be rescored with all other applicants that apply during that filing window.

200.4(8) *Provisional nature of preapplication process.* The preapplication process described in rule 261—200.2(15J) will result in provisional scores and provisional funding decisions for applicants. However, these provisional scores and funding decisions are subject to change pending the final approval process described in rule 261—200.5(15J).

261—200.5(15J) Final application and approval process.

200.5(1) *Final application required.*

a. An applicant that receives a provisional funding decision must submit a final application to the board within one year of the submission of the preapplication.

b. A final application shall meet all the requirements described in Iowa Code section 15J.4 and rule 261—200.3(15J).

200.5(2) *Amendments to preapplications and rescoring of plans.* An applicant may amend any part of the preapplication when submitting the final application and must amend the application if any part of the proposed district plan will be materially different from the plan that was proposed during the preapplication process. If the board determines that a final application is substantially different from the related preapplication, then the board may rescore the application and reevaluate the provisional funding decision prior to taking final action. If the board elects to rescore and reevaluate an application, the application will be rescored and reevaluated in the same manner and according to the same criteria used initially.

200.5(3) *Final funding decision and establishment of commencement date.* After submission of all information required for the final application, the board will make a final funding decision, establish a final maximum benefit amount, and establish a commencement date for the district as described in Iowa Code section 15J.4(3)*"d."*

200.5(4) *Provisional funding decisions not determinative of final funding decision.* The board's final funding decision may be different from its provisional funding decision. The board may ratify, amend, defer, or rescind the provisional funding decision. If the board's final funding decision causes additional funding to become available, the board may amend a funding decision for another proposed district plan made during the same annual filing window or may reserve the additional funding capacity for the next annual filing window.

261—200.6(15J) Adoption of ordinance and use of deposits.

200.6(1) *Ordinance and notice to department.* Upon receiving approval by the board of the final application pursuant to rule 261—200.5(15J), the municipality shall adopt an ordinance or, in the case of a joint board, a resolution establishing the district consistent with Iowa Code section 15J.4(4)*"c."* Notice to the director of revenue shall be provided consistent with Iowa Code section 15J.4(4)*"a"* and *"b."*

200.6(2) *Use of deposits.*

a. For the purpose of determining eligible uses of moneys deposited in an account pursuant to Iowa Code section 15J.4(4)*"d,"* "development" means all costs reasonably related to a project described in a final application approved by the board. Development costs may include project planning, professional services, land acquisition, construction, maintenance, and operational expenses. A municipality shall enter into development agreements for the expenditure of program funds and submit copies of such agreements to the authority within 30 days of execution.

b. Moneys deposited in an account shall only be used to fund projects approved by the board as part of a proposed district plan. Moneys deposited in an account may be used for projects that do not generate new tax revenues, provided such projects are part of an approved plan. A municipality shall maintain records documenting the use of deposits under the program and make them available to the board or the department upon request.

c. Moneys from new tax revenues collected within a district and expended by a municipality under the program are subject to audit by the department or the auditor of state.

261—200.7(15J) Plan amendments and reporting.

200.7(1) *Plan amendments.*

a. Requests for amendments shall include updated or amended feasibility and economic impact studies as determined necessary by the authority. A plan amendment request that does not increase the maximum benefit amount may be requested at any time.

b. A request to extend a district's established commencement date will be rejected.

c. If, after final approval and establishment of the district, a municipality is unable to carry out development of all the projects proposed to be undertaken in a district, the municipality shall seek a modification to the plan. If a requested plan amendment would reduce capital investment in a district or remove one or more of the projects originally approved for the district, the board in its discretion may reduce, rescind, or otherwise modify the maximum benefit amount accordingly.

200.7(2) *Reports.* Following establishment of a district, the municipality shall submit the reports required by Iowa Code section 15J.4(6). Reports will be posted on the authority's website in accordance with Iowa Code section 15J.4(7).

261—200.8(15J) Cessation of deposits, district dissolution, and requests for extension.

200.8(1) *Cessation of deposits.* Deposits to the district's account shall cease in accordance with Iowa Code section 15J.8.

200.8(2) *District dissolution.* If a municipality is notified that its maximum benefit amount has been reached, the municipality shall dissolve the district by ordinance or resolution as soon as practicable after notification.

200.8(3) *Requests for extension.* The board may extend the district's 20-year period of time for depositing and receiving revenues in accordance with Iowa Code section 15J.8(3).

261—200.9(15J) Cross-reference to department rules. The department has adopted rules for the administration and deposit of moneys into the fund and into accounts in 701—Chapter 273.

These rules are intended to implement Iowa Code chapter 15J as amended by 2025 Iowa Acts, House File 975.

ARC 9829C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to major events and tourism program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to adopt new Chapter 201, "Major Events and Tourism Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 15.106A and section 15G.103 as enacted by 2025 Iowa Acts, Senate File 660.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 15G.101 through 15G.104 as enacted by 2025 Iowa Acts, Senate File 660.

Purpose and Summary

Pursuant to Iowa Code sections 15G.101 through 15G.104 as enacted by 2025 Iowa Acts, Senate File 660, the Authority proposes to adopt Chapter 201. The chapter describes the policies and procedures applicable to the Iowa Major Events and Tourism Program. The program provides grants for expenditures associated with event bidding and selection. The chapter will set forth eligibility requirements, application procedures, and review processes for the program.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 15, 2025. A public hearing was held on the following date(s):

- November 4, 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 January 13, 2026. 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 201:

CHAPTER 201
IOWA MAJOR EVENTS AND TOURISM PROGRAM

261—201.1(15G) Definitions.

"Applicant" means an eligible entity that is applying for financial assistance through the program.

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

"Board" means the Iowa economic development authority board.

"Entity" means the same as defined in Iowa Code section 15G.101 as enacted by 2025 Iowa Acts, Senate File 660.

"Event" means the same as defined in Iowa Code section 15G.101 as enacted by 2025 Iowa Acts, Senate File 660.

"Financial assistance" means the same as defined in Iowa Code section 15G.101 as enacted by 2025 Iowa Acts, Senate File 660.

"Matching funds" means a cash contribution made by an entity applying for financial assistance. "Matching funds" does not include any in-kind noncash contributions.

"Program" means the Iowa major events and tourism program administered pursuant to this chapter and Iowa Code sections 15G.101 through 15G.104 as enacted by 2025 Iowa Acts, Senate File 660.

"Recipient" means an entity that has been awarded financial assistance.

261—201.2(15G) Eligibility.

201.2(1) In addition to the eligibility criteria in Iowa Code section 15G.103(2) as enacted by 2025 Iowa Acts, Senate File 660, an event must meet the following criteria to be eligible for financial assistance under the program:

a. The event must be an event that has not previously been held in Iowa or has a quality or qualities that substantially distinguish the event from other events that have been held or could be held in the state.

b. The event must be a ticketed event or require registration.

c. The event will generate significant attendance from an out-of-state audience.

d. The event is or will be held no more frequently than one time annually in Iowa.

e. The hosting rights for the event were not secured by the entity applying for financial assistance before July 1, 2025.

201.2(2) To determine whether an event is a tourism-oriented athletic contest, convention, music festival, or art festival for the purposes of the program, the authority will consider the following factors:

a. Whether the event encourages overnight stays.

b. Whether the event contributes to the vitality of the host region's tourism and economic development activity.

c. Whether the marketing plan for the event targets an audience from more than 50 miles away from the event location.

d. Whether the event elevates the profile of the state as a destination and encourages other events to seek Iowa communities as a host.

261—201.3(15G) Preapplication. Entities interested in applying for financial assistance shall submit a preapplication to the authority in the form and content prescribed by the authority. The preapplication will be evaluated by staff for eligibility based on the criteria in Iowa Code section 15G.103(2) as enacted by 2025 Iowa Acts, Senate File 660, and rule 261—201.2(15G).

261—201.4(15G) Application.

201.4(1) Entities that are invited to apply for the program based on their preapplication and staff review conducted pursuant to rule 261—201.3(15G) shall submit an application to the authority in the form and content prescribed by the authority. The application shall contain the following:

a. An economic analysis that meets the requirements in Iowa Code section 15G.103(2)*"a"*(2) as enacted by 2025 Iowa Acts, Senate File 660.

b. A marketing plan for the event that demonstrates to the satisfaction of the authority that the entity has the capacity and expertise to market the event appropriately.

c. Documentation of the entity's nonprofit status and documentation that the entity is established to promote economic development and tourism in an area.

d. The request for proposals or other comparable documents that the entity has responded to or will respond to in order to secure the event.

e. Documentation of the entity's ability to provide matching funds as required by Iowa Code section 15G.103(4)*"b"* as enacted by 2025 Iowa Acts, Senate File 660.

f. Documentation of the expenditures required as part of the entity's bid for the event.

201.4(2) An application must be for a minimum request of $200,000.

201.4(3) An entity shall submit only one application for the program per bid process.

201.4(4) Authority staff will evaluate each application based on the criteria identified in Iowa Code section 15G.103 as enacted by 2025 Iowa Acts, Senate File 660, and the following criteria:

a. Whether the event would be new to Iowa or has been held in Iowa within the previous three years.

b. Whether receipt of financial assistance will be necessary for a successful bid or selection.

201.4(5) Following staff evaluation, eligible applications will be forwarded to the board for its final funding decision.

261—201.5(15G) Eligible expenses.

201.5(1) Expenditures identified in Iowa Code section 15G.102(2) as enacted by 2025 Iowa Acts, Senate File 660, that are required as part of the entity's bid for an event are eligible for financial assistance.

201.5(2) Expenses for expenditures not directly related to the bidding and selection process are ineligible for reimbursement, including but not limited to:

a. Costs of developing or making permanent improvements to facilities, payroll or operating expenses.

b. Costs otherwise eligible but associated with a recipient-owned or recipient-controlled venue or asset.

c. Items that are purchased for resale.

d. Any item not required as part of the entity's bid for an event.

261—201.6(15G) Administration.

201.6(1) *Notification.* The authority will notify successful applicants in writing of their approved application for financial assistance and prepare an agreement that reflects the terms of the financial assistance. The recipient must execute and return the agreement to the authority within 60 days of the transmittal of the final agreement from the authority. Failure to do so may result in termination of the financial assistance by the authority.

201.6(2) *Disbursement.* Financial assistance will be disbursed on a reimbursement basis. The authority will establish the frequency and amounts available for disbursement in the agreement entered pursuant to subrule 201.6(1).

201.6(3) *Reporting requirements.*

a. Each recipient shall submit an annual report that includes information about the status of the event and any information required by Iowa Code section 8.57.

b. A recipient shall submit information reasonably required by the authority to make reports to the authority's board, the governor's office, or the general assembly.

201.6(4) *Remedies for noncompliance.* If the authority finds that a recipient is not in compliance with program requirements or the terms and conditions of the agreement, the authority may employ any remedies it deems appropriate, including but not limited to the following:

a. Issue a warning letter stating that continued failure to comply with program requirements within a stated period of time will result in a more serious action.

b. Condition future financial assistance on correcting compliance issues.

c. Require that some or all of the financial assistance be remitted to the authority.

d. Elect not to provide future financial assistance to the recipient until appropriate actions are taken to ensure compliance.

e. Prohibit future awards of financial assistance.

These rules are intended to implement Iowa Code sections 15G.101 through 15G.104 as enacted by 2025 Iowa Acts, Senate File 660.

ARC 9834C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to community attraction and tourism program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 211, "Community Attraction and Tourism (CAT) Programs," and to adopt a new Chapter 211, "Community Attraction and Tourism (CAT) Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 15F, subchapter II.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15F, subchapter II.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 211 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Community Attraction and Tourism Program provided by the Authority pursuant to Iowa Code chapter 15F, subchapter II. The program provides grants to assist projects that provide recreational, cultural, entertainment, and educational attractions.

The updated chapter will be more concise throughout. Unnecessary definitions, language that duplicates statute, and language that is duplicated within the chapter will be eliminated. Changes to the program in 2024 Iowa Acts, Senate File 2385, and 2025 Iowa Acts, House File 975, will be incorporated.

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 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 January 15, 2026. 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:

January 13, 2026 9:45 to 10 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
January 15, 2026 9:45 to 10:45 a.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 211 and adopt the following **new** chapter in lieu thereof:

CHAPTER 211
COMMUNITY ATTRACTION AND TOURISM (CAT) PROGRAM

261—211.1(15F) Definitions. When used in this chapter unless the context otherwise requires:

"Attraction" means a permanently located recreational, cultural, educational, or entertainment activity that is available to the general public.

"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.

"CAT" means community attraction and tourism.

"CAT review committee" means the committee established by Iowa Code section 15F.203(2) as amended by 2025 Iowa Acts, Senate File 975.

"Economic development organization" means an entity organized to position a community to take advantage of economic development opportunities and strengthen a community's competitiveness as a place to work and live.

"Local support" means endorsement by local individuals, organizations, and political subdivisions that have a substantial interest in a project.

"Nonfinancial support" may include but is not limited to the value of labor and services. Real property and personal property donated for purposes of the project are considered financial support at their fair market value.

"Public organization" means a not-for-profit economic development organization or other not-for-profit organization, including one that sponsors or supports community or tourism attractions and activities.

"Recipient" means the entity under contract to receive CAT funds and undertake the funded activity.

"School district" means a school corporation organized under Iowa Code chapter 274.

"Vertical infrastructure" means the same as defined in Iowa Code section 15F.203(3).

261—211.2(15F) Eligible applicants. Eligible applicants for CAT funds include cities, counties, public organizations, and school districts in cooperation with a city or county. Any eligible applicant may apply individually or jointly with another eligible applicant or other eligible applicants. A school district must apply jointly with a city or county.

261—211.3(15F) Eligible projects.

211.3(1) Eligible projects provide recreational, cultural, entertainment, and educational opportunities. Funded projects must position a community to take advantage of economic development opportunities in tourism and strengthen a community's competitiveness as a place to work and live. Completed projects must be open to the public for general use.

211.3(2) Eligible CAT projects must be primarily vertical infrastructure projects.

261—211.4(15F) Ineligible projects.

211.4(1) The board shall not approve an application for assistance under this program to refinance an existing loan.

211.4(2) A recipient may not receive more than one CAT award for a single project. However, previously funded projects may receive an additional award(s) if the applicant demonstrates that the funding is to be used for a significant expansion of the project or a new project.

211.4(3) The board shall not approve an application for assistance in which the combination of CAT funds plus other state funds would constitute more than 50 percent of the total project costs.

211.4(4) Work completed and costs incurred, except the acquisition of real estate, prior to the date of a potential CAT award are ineligible for funding under the CAT programs.

261—211.5(15F) Application requirements. Applications for the program must contain all the information identified in Iowa Code section 15F.202(2).

261—211.6(15F) Application procedure. Authority staff will review applications for completeness and eligibility and as described in subrule 211.7(1). A review, analysis, and evaluation from the authority staff will be submitted to the CAT review committee, which will then make a final recommendation to the board for final approval, denial, or deferral.

211.6(1) Applicants must submit a notice of intent to apply on a form provided by the authority. The authority will send standard application forms to those applicants who have submitted a notice of intent to apply. The notice of intent to apply form will be available on the authority's website. The authority can waive this requirement for good cause.

211.6(2) Authority staff may provide technical assistance as necessary. Authority staff and board members may conduct on-site evaluations of proposed projects.

211.6(3) Incomplete or ineligible applications will not be forwarded to the CAT review committee or board for review.

261—211.7(15F) Application review.

211.7(1) Authority staff will review each application for the following information:

a. Whether the application documents local support for the proposed activity.

b. Whether the proposed project is primarily a vertical infrastructure project.

c. Whether at least 65 percent of the funds needed to complete the proposed project have been raised or pledged. Other state funds cannot be counted as match until the applicant can document that at least 50 percent of the funds have been raised. Moneys raised at any time and not yet spent may be considered as local match. Up to 25 percent of the local match may be nonfinancial support.

211.7(2) The CAT review committee shall consider, at a minimum, the criteria identified in Iowa Code section 15F.203(3).

261—211.8(15F) Administration.

211.8(1) *Administration of awards.*

a. A contract shall be executed between the recipient and authority. The authority and the board reserve the right to negotiate terms and conditions of the contract.

b. The recipient must execute and return the contract within 45 days of transmittal of the final contract. Failure to do so may be cause for the board to terminate the award.

c. Certain projects may require that permits or clearances be obtained from other state or local agencies before the project may proceed. Awards may be conditioned upon the timely completion of these requirements.

d. Awards may be conditioned upon commitment of other sources of funds necessary to complete the project.

e. Awards may be conditioned upon the authority's receipt and board approval of an implementation plan for the funded project.

211.8(2) *Disbursement of funds.* Recipients shall submit requests for funds in the manner and on forms prescribed by the authority. Individual requests for funds shall be made in an amount equal to or greater than $1,000 per request, except for the final draw of funds.

211.8(3) *Recordkeeping and retention.* The recipient shall retain all financial records, all supporting documents, and all other records pertinent to the funded CAT project for three years after contract closeout. Representatives of the authority or its designees shall have access to all records belonging to or in use by recipients pertaining to CAT funds.

211.8(4) *Performance reports and reviews.* Upon request of the authority or the board, recipients shall submit performance reports in the manner and on forms prescribed by the authority. Reports shall assess the use of funds and progress of activities. The authority may perform any reviews or site visits necessary to ensure each recipient's performance.

211.8(5) *Amendments to contracts.* Any substantive change to a contract shall be considered an amendment. Substantive changes include time extensions, budget revisions and significant alterations of the funded project that change the scope, location, objectives or scale of the approved project.

Amendments must be requested in writing by the recipient and are not considered valid until approved by the board and confirmed in writing.

211.8(6) *Contract closeout.* Upon project completion, the authority shall initiate contract closeout procedures.

211.8(7) *Compliance with state and local laws and regulations.* Recipients shall comply with all applicable federal, state or local laws, rules or regulations, including but not limited to these rules, any provisions of the Iowa Code governing the program, or the recipient's project or operations.

211.8(8) *Remedies for noncompliance.* At any time before contract closeout, the authority may, for cause, find that a recipient is not in compliance with the requirements of this program. Remedies for noncompliance may include penalties up to and including the return of program funds. Reasons for a finding of noncompliance include but are not limited to the recipient's use of funds for activities not described in the contract, the recipient's failure to complete funded projects in a timely manner, the recipient's failure to comply with applicable federal, state or local laws, rules or regulations, or the lack of a continuing capacity of the recipient to carry out the approved project in a timely manner.

261—211.9(15F) Allocation of funds. Funds shall be allocated in accordance with Iowa Code section 15F.204(5) through 15F.204(8).

These rules are intended to implement Iowa Code chapter 15F, subchapter II as amended by 2025 Iowa Acts, Senate File 975.

ARC 9849C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to sports tourism program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 215, "Sports Tourism Program: Marketing Fund," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 15F, subchapter IV.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15F, subchapter IV.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 215. The chapter describes the policies and procedures applicable to the Sports Tourism Program Marketing Fund administered by the Authority pursuant to Iowa Code chapter 15F, subchapter IV. The program provides eligible applicants with grants for marketing projects that actively and directly support sporting events. The Marketing Fund component of the program was repealed by 2025 Iowa Acts, Senate File 660, so this chapter is no longer necessary.

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 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 January 15, 2026. 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:

January 13, 2026 9:45 to 10 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
January 15, 2026 9:45 to 10 a.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 215**.

ARC 9835C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to sports tourism program and providing an opportunity for public comment

The Economic Development Authority hereby proposes to rescind Chapter 216, "Sports Tourism Program: Infrastructure Fund," and to adopt a new Chapter 216, "Sports Tourism Infrastructure Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 15F, subchapter IV.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 15F, subchapter IV.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 216 and adopt a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Sports Tourism Program Infrastructure Fund administered by the Authority pursuant to Iowa Code chapter 15F, subchapter IV, as amended by 2025 Iowa Acts, House File 975 and Senate File 660. The program provides eligible applicants with grants for infrastructure projects that actively and directly support sporting events.

The updated chapter will be more concise throughout. Unnecessary definitions, language that duplicates statute, and language that is duplicated within the chapter will be eliminated. Changes to the program in 2025 Iowa Acts, House File 975 and Senate File 660, are incorporated.

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 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 January 15, 2026. 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:

January 13, 2026 9:45 to 10 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-economic-development-authority/ieda-red-tape-review
January 15, 2026 9:45 to 10 a.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 216 and adopt the following **new** chapter in lieu thereof:

CHAPTER 216
SPORTS TOURISM INFRASTRUCTURE PROGRAM

261—216.1(15F) Definitions. When used in this chapter, unless the context otherwise requires:

"Accredited colleges and universities" means any college, university, or institution of higher learning that is accredited by the Higher Learning Commission or by an accrediting agency that is recognized by the U.S. Department of Education.

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

"Bid fees" means fees paid as part of proposing a location for an event.

"Board" means the same as defined in Iowa Code section 15.102.

"Financial assistance" means the same as defined in Iowa Code section 15F.401.

"Infrastructure" means land acquisition and construction; major renovations of buildings; and all appurtenant structures, utilities, and site development that are related to the operation of a sporting event.

"Infrastructure fund" means the fund established pursuant to Iowa Code section 15F.404 for purposes of financing sports tourism infrastructure projects.

"Marketing" means planning for or implementing efforts to publicize a sporting event using a range of strategies, tools, and tactics.

"Professional sporting events" means the same as defined in Iowa Code section 15F.401.

"Program" means the sports tourism infrastructure program administered pursuant to this chapter and funded by the infrastructure fund.

"Public entity" means a nonprofit entity.

"Sporting event" means an athletic activity requiring skill or physical prowess, usually competitive in nature and governed by a set of rules provided by a nationally recognized sanctioning body. A sporting event typically includes the placing of competitors into a fixed order of finish depending upon their respective athletic performance within the rules provided for that activity.

"Sports tourism program review committee" or *"review committee"* means the committee established by Iowa Code section 15F.402(2) as amended by 2025 Iowa Acts, House File 975.

261—216.2(15F) Eligible applicants. Eligible applicants are identified in Iowa Code section 15F.401(2)*"a"* as amended by 2025 Iowa Acts, Senate File 660.

261—216.3(15F) Eligible infrastructure projects. Only projects that support sporting events occurring in Iowa are eligible for assistance.

216.3(1) When considering whether to award financial assistance for two fiscal years, the board shall evaluate metrics including the amount of revenue generated by ticket sales, the estimated economic impact, and the number of overnight stays at hotels in the city or county where the sporting event is being held. For example, economic impact may be calculated as total estimated attendance multiplied by daily attendee spending multiplied by average length of stay. If an eligible applicant wishes to supply an alternative formula for calculating economic impact, the applicant must supply a credible source for using an alternative formula. The authority may include such metrics and estimates in a program agreement executed pursuant to Iowa Code section 15F.401.

216.3(2) A city, county, or public entity shall not use financial assistance for costs incurred prior to approval of financial assistance.

216.3(3) Financial assistance shall be provided for sports tourism infrastructure projects that draw a national and international audience and attract a significant number of visitors from outside the state. Factors the authority will consider in determining whether a project is qualified under this subrule include but are not limited to whether the likelihood of a national or international audience is validated by any available data about the anticipated audiences for the event, whether the event is nationally or internationally televised, and projected visitor information or visitor information for similar events held in the state.

261—216.4(15F) Eligible and ineligible infrastructure expenses.

216.4(1) *Eligible expenses.* Examples of eligible expenses include but are not limited to:

a. Land acquisition;
b. Construction;
c. Major renovation of buildings;
d. Site development;
e. Permanent or temporary structures; and
f. Purchase or long-term lease of equipment.

216.4(2) *Ineligible expenses.* Expenses that are not directly related to sporting events or are not considered infrastructure will be ineligible for reimbursement under the program. Examples of ineligible expenses include but are not limited to:

a. Bid fees, rights fees, solicitation efforts, or lobbying fees;
b. Travel costs or compensation of applicant staff;
c. Expenses associated with marketing or promotion;
d. Ongoing operational costs not specifically related to sporting events; and
e. Other costs that the board determines to be ineligible.

261—216.5(15F) Threshold application requirements. To be considered for funding under the program, an application must meet the following threshold application requirements:

216.5(1) There must be demonstrated local support for the proposed activity.

216.5(2) The application must contain a detailed description of the project outlining the sporting event(s) and the infrastructure expenses necessary to support it.

216.5(3) The proposed project budget must be spent on infrastructure that actively and directly supports the sporting event(s).

216.5(4) The application must contain detailed information and projections sufficient to enable the authority to accurately assess the economic impact of the sporting event(s) described in the application. Such information shall include the estimated number of spectators and estimated quality and quantity of advertising and media coverage the sporting event(s) will generate. If the applicant has previously held substantially similar events, the information shall include actual attendance figures from past events and a summary of the advertising and media coverage generated.

261—216.6(15F) Application process.

216.6(1) Applications for assistance under the program shall be submitted to the authority. For those applications that meet the threshold application requirements and the eligibility criteria, the authority shall forward the applications to the board and provide a staff review analysis and evaluation to the sports tourism program review committee and to the board.

216.6(2) When reviewing the applications, the review committee and the authority shall consider the criteria identified in Iowa Code section 15F.402(3) and the following:

a. The extent to which the project would generate additional recreational and cultural attractions or tourism opportunities.

b. The extent to which the sporting event to be supported by the infrastructure project is unique, innovative, or diverse.

216.6(3) Upon review of the recommendations of the review committee, the board shall make final funding decisions in accordance with Iowa Code section 15F.401(5).

261—216.7(15F) Administration.

216.7(1) *Administration of awards.*

a. The agreement entered into pursuant to Iowa Code section 15F.401(8) will include the terms and conditions under which financial assistance must be repaid or penalties incurred in the event the applicant does not fulfill all obligations under the agreement.

b. The applicant must execute and return the agreement within 90 days of the transmittal of the final agreement. Failure to do so may be cause for the board to terminate the award.

c. Financial assistance shall not be provided until all financing for the sports tourism infrastructure project is secured and documented to the satisfaction of the authority.

d. Awards may be conditioned upon authority receipt and board approval of an implementation plan for the funded project.

216.7(2) *Reports.* The report required pursuant to Iowa Code section 15F.401(7) shall be submitted in the manner and on forms prescribed by the authority. The authority may perform any reviews or site visits necessary to ensure performance by the applicant.

216.7(3) *Requests for funds.* Recipients shall submit requests for funds in the manner and on forms prescribed by the authority. Individual requests for funds shall be made in an amount equal to or greater than $1,000 per request, except for the final draw of funds.

216.7(4) *Recordkeeping and retention.* The recipient shall retain all financial records, supporting documents, and other records pertinent to the sports tourism award for three years after contract closeout. Representatives of the authority shall have access to all recipient records that pertain to sports tourism funds.

216.7(5) *Amendments to contracts.* Any substantive change to a contract shall be considered an amendment. Substantive changes include time extensions, budget revisions, and significant alterations of the funded project that change the scope, location, objectives, or scale of the approved project. Amendments must be approved by the board. The authority may execute nonsubstantive or ministerial changes to the contract without board approval.

216.7(6) *Project closeout.* Upon expiration of the agreement, the authority shall initiate project closeout procedures.

216.7(7) *Compliance with state and local laws and regulations.* Recipients shall comply with all applicable federal, state or local laws, rules or regulations, including but not limited to these rules and any provisions of the Iowa Code governing the program or the recipient's project or operations.

216.7(8) *Remedies for noncompliance.* At any time before project closeout, the authority may, for cause, find that a recipient is not in compliance with the requirements of this program. Remedies for noncompliance may include penalties up to and including the return of program funds. Reasons for a finding of noncompliance include but are not limited to the applicant's use of funds for activities not described in the contract; the applicant's failure to complete funded projects in a timely manner; the applicant's failure to comply with applicable federal, state or local laws, rules or regulations; or the lack of a continuing capacity of the applicant to carry out the approved project in a timely manner.

These rules are intended to implement 2022 Iowa Acts, House File 2579, and Iowa Code chapter 15F, subchapter IV as amended by 2025 Iowa Acts, Senate File 660 and House File 975.

ARC 9827C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Notice of Intended Action

Proposing rulemaking related to Iowa film production incentive program and fund and providing an opportunity for public comment

The Economic Development Authority hereby proposes to adopt a new Chapter 300, "Iowa Film Production Incentive Program and Fund," 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, Iowa Code section 15.517.

Purpose and Summary

Pursuant to Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657, the Authority proposes to adopt Chapter 300. The chapter describes the policies and procedures applicable to the Iowa Film Production Incentive Program. The program provides rebates to qualified production facilities to produce qualified productions in the State of Iowa. The chapter will set forth eligibility requirements, application procedures and review processes for the program.

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 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 January 13, 2026. 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 300:

CHAPTER 300
IOWA FILM PRODUCTION INCENTIVE PROGRAM AND FUND

261—300.1(15) Purpose. The Iowa film production incentive program and the Iowa film production incentive fund are created pursuant to and for the purposes stated under Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657.

261—300.2(15) Definitions.

"Applicant" means a qualified production facility that is applying for a rebate under the program.

"Authority" means the Iowa economic development authority.

"Capital expenditure" means money spent to purchase or maintain fixed assets or tangible personal property, including information technology systems, having a useful life of more than one year.

"Certified public accountant" means the same as defined in Iowa Code section 542.3.

"Fringes" means payroll fees (excluding taxes), union and guild fees, insurance benefits, and worker's compensation, specific to the production for which an applicant is applying for a program rebate.

"Iowa business" means a business registered and in good standing with the Iowa secretary of state.

"Postproduction" means the activities preparing the film or television program for final showing, including editing and sound design.

"Preproduction" means activities enabling the start of principal photography in Iowa, including hiring local cast and crew and final location scouting.

"Principal photography" means the production phase in which the bulk of shooting takes place.

"Program" means the Iowa film production incentive program created pursuant to Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657.

"Qualified expenditure" means the same as defined in Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657, and meeting the criteria in rule 261—300.5(15).

"Qualified production" means the same as defined in Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657.

"Qualified production facility" means the same as defined in Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657.

"Rebate" means a rebate disbursed to a recipient pursuant to Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657, after the recipient complies with all of the reporting requirements under rule 261—300.6(15).

"Recipient" means a qualified production facility that has been awarded a program rebate.

"Studio" means a company that produces and has a dedicated physical space for the production of video entertainment.

261—300.3(15) Eligible applicants. An applicant must be a qualified production facility producing a qualified production and meeting the following criteria:

300.3(1) The production will have a total production budget of at least $1,000,000, including a minimum of $500,000 in qualified expenditures.

300.3(2) The production will be made available to the public for viewing at a venue where admission is charged or made available for purchase, for rental, or through a streaming service that requires a subscription.

300.3(3) Principal photography has not started as of the date of the application submission.

300.3(4) If applying for more than one qualified production, only one application per production is submitted.

300.3(5) The production must be a feature film, television series, documentary or unscripted series.

261—300.4(15) Application process.

300.4(1) Applicants applying for the first time under the program, or as otherwise required by the authority, must submit a qualified production facility certification in the form and content prescribed by the authority as part of the application process.

300.4(2) Applicants must electronically file their program application in the form and content prescribed by the authority.

300.4(3) Applications will be reviewed by the authority for award of a program rebate. Payment of the rebate will be made only after completion of the applicant's qualified production and submission of the materials specified in rule 261—300.6(15).

300.4(4) Factors the authority may consider when reviewing an application include:

a. Extent to which the applicant will participate in training, education, and recruitment programs that are organized in cooperation with interested Iowa colleges and universities and that are designed to promote and encourage the training and hiring of Iowa residents.

b. Whether the rebate will incentivize the applicant to choose an Iowa location for its production over an out-of-state location.

c. Likelihood that approval of the rebate will result in an overall long-term positive impact to Iowa.

300.4(5) Based on the review process and subject to available funding, the authority may revise an applicant's overall funding request.

300.4(6) The authority will notify successful applicants in writing of their approved application for a rebate and prepare an agreement that reflects the terms of the award. A recipient must execute and return the agreement to the authority within 30 days of the transmittal of the final agreement from the authority. Failure to do so may result in the termination of the award by the authority.

261—300.5(15) Qualified expenditures.

300.5(1) Qualified expenditures are expenditures incurred for industry standard preproduction, production and post-production expenses paid to Iowa businesses or to production personnel, crew and cast physically working on the production in Iowa. Qualified expenditures include:

a. Wages and fringes for personnel, crew and cast members.

b. Equipment rentals.

c. Equipment purchases, not to exceed $5,000 per unit.

d. Rental of facilities, including other studio production facilities, located within the boundaries of Iowa that are not owned, managed or operated by the applicant or by a subsidiary, parent, affiliated or associated entity of applicant.

e. Hospitality services.

f. Certified public accountant services.

g. Per diem payments.

h. Accommodations within the boundaries of Iowa and certified in compliance with Iowa Code section 80.45A.

i. Transportation, limited to mileage at standard Internal Revenue Service (IRS) rates and rental fees paid to Iowa businesses and full-time Iowa residents for vehicle rentals.

j. Fees for submission to film festivals in Iowa.

k. Temporary set-based construction.

l. Services that directly support standard preproduction, production and postproduction expenses (e.g., security, police, fire services).

300.5(2) Qualified expenditures do not include:

a. Entertainment.

b. Airfare.

c. Royalties.

d. Publicity.

e. Compensation paid to employees with a financial interest in the recipient entity.

f. Permanent facility-based construction.

g. Capital expenditures.

h. Sales, use and hotel and motel taxes.

261—300.6(15) Reporting requirements and rebate.

300.6(1) A recipient shall complete and submit all reports required by the program agreement. A recipient shall submit any information requested by the authority in sufficient detail to permit the authority to prepare any reports required by the authority, the general assembly or the governor's office.

300.6(2) The maximum rebate paid to a recipient will equal 30 percent of the recipient's documented qualified expenditures. The rebate amount shall not exceed the award amount specified in the notice of award and the program agreement unless otherwise agreed to by the authority in writing. Any decision by the authority on the rebate amount shall be made in the sole discretion of the authority and shall be final.

These rules are intended to implement Iowa Code section 15.517 as enacted by 2025 Iowa Acts, Senate File 657.

ARC 9866C

HIGHER EDUCATION LOAN AUTHORITY[284]

Notice of Intended Action

Proposing rulemaking related to organization and operation and providing an opportunity for public comment

The Higher Education Loan Authority hereby proposes to rescind Chapter 1, "Organization and Operation," and to adopt a new Chapter 1 "Organization and Operations," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 261A.7.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 261A.7.

Purpose and Summary

The Authority serves Iowa's independent nonprofit colleges and universities by providing affordable financing of facilities and working capital through the issuance of tax-exempt debt on the colleges' and universities' behalf. This proposed rulemaking repromulgates Chapter 1, which contains rules related to organization and operations of the Authority.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 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.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Maribeth Wright
Iowa Higher Education Loan Authority
1105 High Street
P.O. Box 214
Norwalk, Iowa 50211
Email: maribeth.wright@ihela.org

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 to 9:45 a.m.	Via Zoom us06web.zoom.us/j/83021252579?pwd= DMtPYz6JI4CFGzzLDZjqffdVQMX8cW.1 Meeting ID: 830 2125 2579 Passcode: 826840
January 13, 2026 2:30 to 3:15 p.m.	Via Zoom us06web.zoom.us/j/87133458123?pwd= y0LH6z71ov0s3YJ4Sd3KvzYsT7ctSz.1 Meeting ID: 871 3345 8123 Passcode: 735526

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 284—Chapter 1 and adopt the following **new** chapter in lieu thereof:

CHAPTER 1
ORGANIZATION AND OPERATIONS

284—1.1(261A) Organization and operations.

1.1(1) *Location.* The mailing address of the authority is located at 1105 High Road, Box 214, Norwalk, Iowa 50211.

1.1(2) *The authority.* The powers of the authority are vested in and exercised by the members of the authority pursuant to Iowa Code chapter 261A.

1.1(3) *Meetings.*

a. The chairperson of the authority presides at each meeting. Members of the public may be recognized at the discretion of the chairperson. All meetings are open to the public in accordance with the open meetings law, Iowa Code chapter 21.

b. Public notice. The authority will give advance public notice of the specific date, time and place of each authority meeting.

1.1(4) *Minutes.* The minutes of all authority meetings are recorded by the secretary and kept in the authority's possession.

1.1(5) *Submission and requests.* Inquiries, submissions, petitions, and other requests directed to the authority may be made in writing addressed to the authority's mailing address listed in subrule 1.1(1). Any person may petition for a written or oral hearing before the authority. All requests for a hearing are in writing and state the specific subject to be discussed and the reasons why a personal appearance is necessary if one is requested.

1.1(6) *Administration of programs.* The authority may adopt manuals, instructions or other statements as necessary to assist its employees in administering its programs and to permit individuals

and organizations to participate in programs administered by the authority. Copies of all manuals, instructions and other statements are kept in the authority's possession and are available for public inspection, except for those portions that are excluded from the definition of "rule" by Iowa Code section 17A.2(11)*"f"* or that must be kept confidential under applicable statutes or these rules. Members of the public may inspect the materials adopted pursuant to this rule, subject to the exceptions set out above, during regular business hours and may obtain a reasonable number of copies of the materials upon payment of a fee not to exceed the cost of providing copies.

This rule is intended to implement Iowa Code chapter 261A.

ARC 9867C

HIGHER EDUCATION LOAN AUTHORITY[284]

Notice of Intended Action

Proposing rulemaking related to petitions for rulemaking and providing an opportunity for public comment

The Higher Education Loan Authority hereby proposes to rescind Chapter 2, "Petitions for Rule Making," and to adopt a new Chapter 2, "Petitions for Rulemaking," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 261A.7.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 261A.7.

Purpose and Summary

The Authority serves Iowa's independent nonprofit colleges and universities by providing affordable financing of facilities and working capital through the issuance of tax-exempt debt on the colleges' and universities' behalf. This proposed rulemaking repromulgates Chapter 2, which contains rules related to petitions for rulemaking.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 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.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Maribeth Wright
Iowa Higher Education Loan Authority
1105 High Street
P.O. Box 214
Norwalk, Iowa 50211
Email: maribeth.wright@ihela.org

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 to 9:30 a.m.	Via Zoom us06web.zoom.us/j/83021252579?pwd= DMtPYz6JI4CFGzzLDZjqffdVQMX8cW.1 Meeting ID: 830 2125 2579 Passcode: 826840
January 13, 2026 2:30 to 3:15 p.m.	Via Zoom us06web.zoom.us/j/87133458123?pwd= y0LH6z71ov0s3YJ4Sd3KvzYsT7ctSz.1 Meeting ID: 871 3345 8123 Passcode: 735526

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 284—Chapter 2 and adopt the following **new** chapter in lieu thereof:

CHAPTER 2
PETITIONS FOR RULEMAKING

The higher education loan authority 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.

284—2.1(261A) Petition for rulemaking. In lieu of the words "(AGENCY NAME)", the heading on the petition form should read:

IOWA HIGHER EDUCATION LOAN AUTHORITY

284—2.3(261A) Inquiries. Inquiries concerning the status of a petition for rulemaking may be made to the Executive Director, 1105 High Road, Box 214, Norwalk, Iowa 50211.

These rules are intended to implement Iowa Code section 17A.24 and chapter 261A.

ARC 9868C

HIGHER EDUCATION LOAN AUTHORITY[284]

Notice of Intended Action

Proposing rulemaking related to declaratory orders and providing an opportunity for public comment

The Higher Education Loan Authority hereby proposes to rescind Chapter 3, "Declaratory Rulings," and to adopt a new Chapter 3, "Declaratory Orders," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 261A.7.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 261A.7.

Purpose and Summary

The Authority serves Iowa's independent nonprofit colleges and universities providing affordable financing of facilities and working capital through the issuance of tax-exempt debt on the colleges' and universities' behalf. This proposed rulemaking repromulgates Chapter 3, which contains rules related to declaratory orders.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 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.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Maribeth Wright
Iowa Higher Education Loan Authority
1105 High Street
P.O. Box 214
Norwalk, Iowa 50211
Email: maribeth.wright@ihela.org

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 to 9:45 a.m.	Via Zoom us06web.zoom.us/j/83021252579?pwd= DMtPYz6JI4CFGzzLDZjqffdVQMX8cW.1 Meeting ID: 830 2125 2579 Passcode: 826840
January 13, 2026 2:30 to 3:15 p.m.	Via Zoom us06web.zoom.us/j/87133458123?pwd= y0LH6z71ov0s3YJ4Sd3KvzYsT7ctSz.1 Meeting ID: 871 3345 8123 Passcode: 735526

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 284—Chapter 3 and adopt the following **new** chapter in lieu thereof:

CHAPTER 3
DECLARATORY ORDERS

The higher education loan authority 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.

284—3.1(261A) Petition for declaratory orders. In lieu of the words "(AGENCY NAME)", the heading on the petition form should read:

IOWA HIGHER EDUCATION LOAN AUTHORITY

284—3.5(261A) Inquiries. Inquiries concerning the status of a petition for a declaratory order may be made to the Executive Director, 1105 High Road, Box 214, Norwalk, Iowa 50211.

These rules are intended to implement Iowa Code section 17A.24 and chapter 261A.

ARC 9869C

HIGHER EDUCATION LOAN AUTHORITY[284]

Notice of Intended Action

Proposing rulemaking related to agency procedure for rulemaking and providing an opportunity for public comment

The Higher Education Loan Authority hereby proposes to rescind Chapter 4, "Agency Procedure for Rule Making," and to adopt a new Chapter 4, "Agency Procedure for Rulemaking," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 261A.7.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 261A.7.

Purpose and Summary

The Authority serves Iowa's independent nonprofit colleges and universities by providing affordable financing of facilities and working capital through the issuance of tax-exempt debt on the colleges' and universities' behalf. This proposed rulemaking repromulgates Chapter 4, which contains rules related to agency procedure for rulemaking.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 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.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Maribeth Wright
Iowa Higher Education Loan Authority
1105 High Street
P.O. Box 214
Norwalk, Iowa 50211
Email: maribeth.wright@ihela.org

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 to 9:45 a.m.	Via Zoom us06web.zoom.us/j/83021252579?pwd= DMtPYz6JI4CFGzzLDZjqffdVQMX8cW.1 Meeting ID: 830 2125 2579 Passcode: 826840

January 13, 2026 2:30 to 3:15 p.m.	Via Zoom us06web.zoom.us/j/87133458123?pwd= y0LH6z71ov0s3YJ4Sd3KvzYsT7ctSz.1 Meeting ID: 871 3345 8123 Passcode: 735526

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 284—Chapter 4 and adopt the following **new** chapter in lieu thereof:

CHAPTER 4
AGENCY PROCEDURE FOR RULEMAKING

The higher education loan authority 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.

284—4.3(261A) Public rulemaking docket.

4.3(2) *Anticipated rulemaking.* In lieu of the words "(commission, board, council, director)", insert "authority".

284—4.4(261A) Notice of proposed rulemaking.

4.4(3) *Copies of notices.* In lieu of the words "(specify time period)", insert "three years".

284—4.5(261A) Public participation.

4.5(1) *Written comments.* In lieu of the words "(identify office and address)", insert "Iowa Higher Education Loan Authority, 1105 High Road, Box 214, Norwalk, Iowa 50211".

284—4.6(261A) Regulatory analysis.

4.6(2) *Mailing list.* In lieu of the words "(designate office)", insert "Iowa Higher Education Loan Authority, 1105 High Road, Box 214, Norwalk, Iowa 50211".

284—4.10(261A) Exemptions from public rulemaking procedures.

4.10(2) Reserved.

284—4.11(261A) Concise statement of reasons.

4.11(1) *General.* In lieu of the words "(specify the office and address)", insert "Iowa Higher Education Loan Authority, 1105 High Road, Box 214, Norwalk, Iowa 50211".

284—4.13(261A) Agency rulemaking record.

4.13(2) *Contents.*

c. In lieu of the words "(agency head)", insert "executive director".

These rules are intended to implement Iowa Code section 17A.24 and chapter 261A.

ARC 9870C

HIGHER EDUCATION LOAN AUTHORITY[284]

Notice of Intended Action

Proposing rulemaking related to public records and fair information practices and providing an opportunity for public comment

The Higher Education Loan Authority hereby proposes to rescind Chapter 5, "Public Records and Fair Information Practices," Iowa Administrative Code, and to adopt a new Chapter 5 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 261A.7.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 261A.7.

Purpose and Summary

The Authority serves Iowa's independent nonprofit colleges and universities by providing affordable financing of facilities and working capital through the issuance of tax-exempt debt on the colleges' and universities' behalf. This proposed rulemaking repromulgates Chapter 5, which contains rules related to fair information practices.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 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.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Maribeth Wright
Iowa Higher Education Loan Authority
1105 High Street
P.O. Box 214
Norwalk, Iowa 50211
Email: maribeth.wright@ihela.org

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 to 9:45 a.m.	Via Zoom us06web.zoom.us/j/83021252579?pwd= DMtPYz6JI4CFGzzLDZjqffdVQMX8cW.1 Meeting ID: 830 2125 2579 Passcode: 826840
January 13, 2026 2:30 to 3:15 p.m.	Via Zoom us06web.zoom.us/j/87133458123?pwd= y0LH6z71ov0s3YJ4Sd3KvzYsT7ctSz.1 Meeting ID: 871 3345 8123 Passcode: 735526

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 284—Chapter 5 and adopt the following **new** chapter in lieu thereof:

CHAPTER 5
FAIR INFORMATION PRACTICES

The Iowa higher education loan authority 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.

284—5.1(261A) Definition. As used in this chapter:

"Agency" or *"authority"* means the Iowa higher education loan authority.

284—5.3(261A) Requests for access to records.

5.3(1) *Location of record.* In lieu of the words "(insert agency head)", insert "executive director", and in lieu of the words "(insert agency name and address)", insert "Iowa Higher Education Loan Authority at 1105 High Road, Box 214, Norwalk, Iowa 50211".

5.3(2) *Office hours.* Records are made available from 9 a.m. to 12 noon and from 1 p.m. to 4 p.m. daily, excluding Saturdays, Sundays and legal holidays.

5.3(3) *Request for access.* In lieu of the first sentence, insert "Requests for access to open records may be made in writing or by telephone."

5.3(7) *Fees.*

c. *Supervisory fee.* Reserved.

d. *Advance deposits.* Reserved.

284—5.6(261A) Procedure by which additions, dissents, or objections may be entered into certain records. In lieu of the words "(designate office)", insert "Iowa Higher Education Loan Authority, 1105 High Road, Box 214, Norwalk, Iowa 50211".

These rules are intended to implement Iowa Code section 17A.24 and chapter 261A.

ARC 9825C

HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]

Notice of Intended Action

Proposing rulemaking related to 911 telephone systems and providing an opportunity for public comment

The Homeland Security and Emergency Management Department hereby proposes to rescind Chapter 10, "911 Telephone Systems," Iowa Administrative Code, and to adopt a new Chapter 10 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 34A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 34A.

Purpose and Summary

The proposed rulemaking eliminates language this is overly restrictive, obsolete, and repetitive of the Iowa Code and is therefore a shorter chapter.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 19, 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 January 14, 2026. Comments should be directed to:

Blake DeRouchey
Department of Homeland Security and Emergency Management

7900 Hickman Road, Suite 500
Windsor Heights, Iowa 50324
Phone: 515.323.4232
Email: blake.derouchey@iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 12:30 p.m.	Geode Room 7900 Hickman Road Windsor Heights, Iowa Video call link: meet.google.com/oqm-wujn-dif Or dial: (US) +1 475.277.0077 PIN: 619 998 977#
January 14, 2026 9 a.m.	Geode Room 7900 Hickman Road Windsor Heights, Iowa Video call link: meet.google.com/oqm-wujn-dif Or dial: (US) +1 475.277.0077 PIN: 619 998 977#

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 605—Chapter 10 and adopt the following **new** chapter in lieu thereof:

CHAPTER 10
911 TELEPHONE SYSTEMS

605—10.1(34A) Program description. In addition to the purpose described in Iowa Code section 34A.1, the purpose of this program is to provide for the orderly development, installation, and operation of 911 emergency telephone systems and to provide a mechanism for the funding of these systems, either in whole or in part.

605—10.2(34A) Definitions. All terms defined in Iowa Code section 34A.2 apply to this chapter, as well as the following terms:

"911 authority" means the public entity at the state or local level that operates a 911 telephone system for the public benefit within a defined 911 service area.

"911 communications council" means the council as established under the provisions of Iowa Code section 34A.15.

"911 emergency call" or *"911 call"* means a communication initiated using the digits 911 and transported via the next generation 911 network that includes voice, text, picture, multimedia, or any other type of data that is sent to a PSAP for the purpose of requesting emergency assistance.

"911 program manager" means the individual appointed by the director and working with the 911 communications council to perform the duties specifically set forth in Iowa Code chapter 34A and this chapter.

"911 system" means a telephone system that automatically connects a caller dialing the digits 911, transported via the Next Generation 911 (NG911) network, to a public safety answering point (PSAP).

"Access line" means an exchange access line that has the ability to place a 911 call and reach a PSAP.

"Automatic location identification" or *"ALI"* means a system capability that enables an automatic display of information defining a geographical location of the telephone used to place the 911 call.

"Automatic number identification" or *"ANI"* means a capability that enables the automatic display of the number of the telephone used to place the 911 call.

"Central office" or *"CO"* means a telephone company facility that houses the switching equipment for connecting subscribers to each other.

"Department" means the same as defined in Iowa Code section 29C.2.

"Entry point" means the demarcation point(s), as designated by the 911 program manager, where originating service providers must deliver their 911 traffic for ingress into the state's NG911 network.

"ESInet" means the same as defined in Iowa Code section 34A.2.

"Exchange" means a defined geographic area served by one or more central offices in which the telephone company furnishes services.

"Logging recorder" means a device that electronically records voice 911 calls and may also record associated radio traffic and call data. The logging recorder automatically logs the time and date of such conversations; normally, it is a multichannel device that keeps a semipermanent record of operations for archival or evidentiary purposes.

"Multi-line telephone system" or *"MLTS"* means the same as described in 47 CFR §9.3.

"Political subdivision" means a geographic or territorial division of the state that would have the following characteristics: defined geographic area, responsibilities for certain functions of local government, public elections and public officers, and taxing power. Excluded from this definition are departments and divisions of state government and agencies of the federal government.

"Prepaid wireless telecommunications service" means the service described in Iowa Code section 34A.7B and 701—Chapter 217.

"Provider" means a person, company or other business that provides, or offers to provide, 911 equipment, installation, maintenance, or access services.

"Public safety telecommunicator" or *"telecommunicator"* means the same as defined in Iowa Code section 80B.11C.

"Public switched network" means the same as described in 47 CFR §9.3.

"Subscriber" means any person; firm; association; corporation; agencies of federal, state and local government; or other legal entity responsible by law for payment for communication service from the telephone utility.

"Text telephone" or *"TTY"* means the same as described in 47 CFR §9.3.

"Wireless communications service" means commercial mobile radio service. "Wireless communications service" includes any wireless two-way communications used in cellular telephone service; personal communications service; or the functional or competitive equivalent of a radio-telephone communications line used in cellular telephone service, a personal communications service, or a network access line. "Wireless communications service" does not include a service whose customers do not have access to a 911 or 911-like service, a communications channel utilized only for data transmission, or a private telecommunications system.

605—10.3(34A) Joint 911 service boards. This rule assists 911 authorities in administering Iowa Code section 34A.3.

10.3(1) The joint 911 service board shall submit a listing of members along with the chair and vice chair. The submission will be on a form prescribed by the 911 program manager and will include the political subdivision each member represents and, if applicable, the associated Iowa Code chapter 28E

or alternate 911 service board as described in Iowa Code sections 34A.3(4) and 29C.9(10). A copy of the list will be submitted annually along with a time frame communicated by the program manager and listed on the prescribed form.

10.3(2) Joint 911 service board bylaws.

a. Each joint 911 service board shall develop bylaws to specify, at a minimum, the following information:

(1) The name of the joint 911 service board.

(2) A list of voting and nonvoting members.

(3) The date for the commencement of operations.

(4) The mission.

(5) The powers and duties.

(6) The manner for financing activities and maintaining a budget.

(7) The manner for acquiring, holding and disposing of property.

(8) The manner for electing or appointing officers and terms of office.

(9) The manner by which members may vote to include, if applicable, the manner by which votes may be weighted.

(10) The manner for appointing, hiring, disciplining, and terminating employees.

(11) The rules for conducting meetings.

(12) The permissible method or methods to be employed in accomplishing the partial or complete termination of the board and the disposing of property upon such complete or partial termination.

(13) Any other necessary and proper rules or procedures.

b. Each member shall sign the adopted bylaws.

c. The joint 911 service board shall record the signed bylaws with the county recorder and shall forward a copy of the signed bylaws to the 911 program manager.

10.3(3) Executive board. The joint 911 service board may, through its bylaws, establish an executive board to conduct the business of the joint 911 service board. Members of the executive board must be selected from the eligible voting members of the joint 911 service board. The executive board will have such other duties and responsibilities as assigned by the joint 911 service board.

10.3(4) Meetings.

a. The provisions of Iowa Code chapter 21 are applicable to joint 911 service boards.

b. Joint 911 service boards shall conduct meetings in accordance with their established bylaws and applicable state law.

10.3(5) The program manager may maintain a template of minimum requirements to satisfy this rule on the department's website.

605—10.4(34A) 911 service plan.

10.4(1) The joint 911 service board shall be responsible for developing a 911 service plan as required by Iowa Code section 34A.3 and as set forth in these rules. The plan will remain the property of the joint 911 service board. Each joint 911 service board will coordinate planning with each contiguous joint 911 service board. A copy of the plan and any modifications and addenda shall be submitted to:

a. The department.

b. All public and private safety agencies serving the 911 service area.

c. All providers affected by the 911 service plan.

10.4(2) In addition to the requirements in Iowa Code section 34A.3, the 911 service plan shall include:

a. The mailing address of the joint 911 service board.

b. A list of voting members on the joint 911 service board.

c. A list of nonvoting members on the joint 911 service board.

d. The name of the chairperson and of the vice chairperson of the joint 911 service board.

e. Maps of the 911 service area showing boundaries for all of the law enforcement agencies, firefighting districts, and ambulance and emergency medical service areas. The location of each PSAP

within the service area shall be uploaded and maintained within the program's online NG911 GIS database via the process described in Iowa Code section 10.12(1)*"f."*

10.4(3) The requirements listed in Iowa Code section 10.4(2)*"b"* through *"d"* may be updated annually via the process described in Iowa Code section 10.3(1).

10.4(4) All plan modifications and addenda shall be filed with, reviewed, and approved by the 911 program manager.

10.4(5) The 911 program manager shall base acceptance of the plan upon compliance with the provisions of Iowa Code chapter 34A and the rules herein.

10.4(6) The 911 program manager will notify in writing, within 20 days of review, the chairperson of the joint 911 service board of the approval or disapproval of the plan.

a. If the plan is disapproved, the joint 911 service board will have 90 days from receipt of notice to submit revisions/addenda.

b. Notice for disapproved plans will contain the reasons for disapproval.

c. The 911 program manager will notify the chairperson, in writing within 20 days of review, of the approval or disapproval of the revisions.

10.4(7) The program manager may maintain a template of minimum service plan requirements on the department's website.

605—10.5(34A) Wireline 911 surcharge. This rule is implemented to help 911 authorities administer Iowa Code section 34A.7.

10.5(1) For the purposes of surcharge remittance and collection, Fixed Interconnected VoIP, as described in 47 CFR Part 9, shall be considered wireline service.

10.5(2) The provider shall remit the collected surcharge to the joint 911 service board on a calendar quarter basis within 20 days of the end of the quarter.

10.5(3) The joint 911 service board may request, not more than once each quarter, the following information from the carrier or provider:

a. The identity of the exchange from which the surcharge is collected.

b. The number of lines to which the surcharge was applied for the quarter.

c. The number of refusals to pay per exchange, if applicable.

d. The number of write-offs per exchange, if applicable.

e. The number of lines exempt per exchange.

f. The amount retained by the carrier or provider from the 1 percent administrative fee.

NOTE: Access line counts and surcharge remittances are confidential public records as provided in Iowa Code section 34A.8.

10.5(4) If the joint 911 service board ceases to operate 911 service, the balance in the 911 service fund shall be payable to the 911 authority taking over the responsibility of the 911 service area.

605—10.6(34A) Wireline 911 surcharge exemptions.

10.6(1) The following agencies, individuals, and organizations are exempt from imposition of the 911 surcharge:

a. Federal agencies and tax-exempt instrumentalities of the federal government.

b. Indian tribes for access lines on the tribe's reservation upon filing a statement with the joint 911 service board, signed by appropriate authority, requesting surcharge exemption.

c. An enrolled member of an Indian tribe for access lines on the reservation, who does not receive 911 service, and who annually files a signed statement with the joint 911 service board that the person is an enrolled member of an Indian tribe living on a reservation and does not receive 911 service. However, once 911 service is provided, the member is no longer exempt.

d. Official station testing lines owned by the provider.

e. Individual wireline subscribers above the maximum access lines as provided for in Iowa Code section 34A.7.

10.6(2) All other subscribers not listed above that have or will have the ability to access 911 are required to pay the surcharge.

605—10.7(34A) Emergency communications service surcharge. This rule is implemented to help 911 authorities administer Iowa Code section 34A.7A.

10.7(1) Surcharge funds shall be remitted on a calendar quarter basis by the close of business on the twentieth day following the end of the quarter with a remittance form as prescribed by the 911 program manager. Providers shall issue their checks or warrants to the Treasurer, State of Iowa, and remit to 911 Program Manager, Iowa Department of Homeland Security and Emergency Management, 7900 Hickman Road, Suite 500, Windsor Heights, Iowa 50324.

10.7(2) For the purposes of surcharge remittance and collection, Non-Fixed VoIP, as described in 47 CFR Part 9, shall be considered wireless service.

10.7(3) Payments to NG911 network service providers, 911 call processing equipment providers, 911 call transport providers, and third-party 911 automatic location identification database providers shall be made quarterly, based on original, itemized claims or invoices presented within 20 days of the end of the calendar quarter. Claims or invoices not submitted within 20 days of the end of the calendar quarter are not eligible for reimbursement and may not be included in future claims and invoices. Payments to providers shall be made in accordance with these rules and the State Accounting Policy and Procedures Manual.

10.7(4) NG911 network service providers, 911 call processing equipment providers, 911 call transport providers, and third-party 911 automatic location identification database providers shall be reimbursed for only those items and services that are defined as eligible in the NG911 Network Implementation and Operations Plan and when initiation of service has been ordered and authorized by the 911 program manager.

10.7(5) If it is found that an overpayment has been made to an entity, the 911 program manager shall attempt recovery of the debt from the entity by certified letter. Due diligence shall be documented and retained by the department. If resolution of the debt does not occur and the debt is at least $50, the department will then utilize the income offset program through the department of revenue. Until resolution of the debt has occurred, the department may withhold future payments to the entity.

605—10.8(34A) Prepaid wireless 911 surcharge. Administration of the prepaid wireless 911 surcharge will be conducted per Iowa Code section 34A.7B and rule 701—217.8(34A).

605—10.9(34A) 911 service fund.

10.9(1) The department of public safety and each joint 911 service board have the responsibility for the 911 service fund consisting of revenue described in Iowa Code section 34A.7.

a. A 911 service fund shall be established in the office of the county treasurer for each joint 911 service board and with the state treasurer for the department of public safety.

b. Collected surcharge moneys and any interest thereon, as authorized in Iowa Code chapter 34A, shall be deposited into the 911 service fund. 911 surcharge moneys must be kept separate from all other sources of revenue utilized for 911 systems.

c. For joint 911 service boards, withdrawal of moneys from the 911 service fund shall be made on warrants drawn by the county auditor, per Iowa Code section 331.506, supported by claims and vouchers approved by the chairperson or vice chairperson of the joint 911 service board or delegated authority so designated in writing.

d. For the department of public safety, withdrawal of moneys from the 911 service fund shall be made in accordance with state laws and administrative rules.

10.9(2) The 911 service funds shall be subject to examination by the department at any time during usual business hours. 911 service funds are subject to the audit provisions of Iowa Code chapter 11. A copy of all audits of the 911 service fund shall be furnished to the department within 30 days of receipt. If through the audit or monitoring process the department determines that a joint 911 service board is not adhering to an approved plan or does not have a valid board membership, or if the department determines that a joint 911 service board or the department of public safety is not using funds in the manner prescribed in these rules or Iowa Code chapter 34A, the director may, after notice and hearing, suspend remittance distribution described in Iowa Code section 34A.7A and order termination

of expenditures from the 911 service fund. The joint 911 service board or department of public safety is not eligible to receive or expend surcharge moneys until such time as the 911 program manager determines that the board or department of public safety is in compliance with the approved plan, board membership, and fund usage limitations.

10.9(3) The program manager will provide common allowable expenditures in the NG911 Operations Plan detailed in rule 605—10.10(34A).

605—10.10(34A) NG911 Network Implementation and Operations Plan. Each joint 911 service board, the department of public safety, the 911 communications council, and originating service providers shall cooperate with the 911 program manager in preparing the NG911 Network Implementation and Operations Plan for statewide implementation of NG911 service.

10.10(1) *Plan specifications.* The NG911 Network Implementation and Operations Plan shall include, at a minimum, the following information:

a. Maps showing the geographic location within the county of each PSAP that receives 911 emergency calls.

b. A list of all PSAPs within the state of Iowa.

c. A set of guidelines for determining eligible costs as set forth in Iowa Code chapter 34A.

d. A schedule for the implementation and maintenance of the NG911 network.

e. A schedule for the implementation, maintenance and cost sharing of 911 call processing equipment.

10.10(2) *Adoption by reference.* The NG911 Network Implementation and Operations Plan, effective July 1, 2018, and available from the Iowa Department of Homeland Security and Emergency Management, 7900 Hickman Road, Suite 500, Windsor Heights, Iowa, or at the Law Library in the Capitol Building, Des Moines, Iowa, is hereby adopted by reference effective August 8, 2018.

605—10.11(34A) Minimum operational and technical standards. 47 CFR Part 9 as of December 1, 2025, is adopted by reference with the following additional specifications:

10.11(1) Each 911 system, supplemented with 911 surcharge moneys, shall, at a minimum, employ the following features:

a. ALI.

b. ANI.

c. Policy routing function.

d. Each PSAP shall maintain an alternate means of receiving emergency calls from the public during an ESInet outage or degradation.

e. ANI and ALI information shall be maintained and updated in such a manner as to allow for 95 percent or greater degree of accuracy.

f. All 911 authorities shall maintain NG911 GIS data according to standards published by the department and posted to the department's website.

10.11(2) 911 public safety answering points shall adhere to the following minimum standards:

a. The PSAP shall operate seven days per week, 24 hours per day, with trained public safety telecommunicators on duty at all times.

b. The primary published emergency number in the 911 service area shall be 911.

c. All PSAPs will maintain interagency communications capabilities for emergency coordination purposes to include radio as well as the Public Switched Network.

d. Each PSAP shall develop and maintain a PSAP standard operating procedure for receiving and dispatching emergency calls.

e. 911 calls should only be transferred as necessary for faster dispatch of responders and to PSAPs that are capable of accepting all associated data, including ANI and ALI.

f. PSAPs shall maintain a logging recorder. Each 911 call shall be recorded using a logging recorder. Call recordings shall be maintained for a period of not less than one year.

g. Access control and security of PSAPs and associated dispatch centers shall be designed to prevent disruption of operations and provide a safe and secure environment of communication operations.

h. 911 authorities shall ensure that all vendors whose normal activities may involve contact with facilities associated with the 911 service are familiar with safeguarding of facilities' procedures.

i. Emergency electrical power shall be provided for the PSAP environment that will ensure continuous operations and communications during a power outage. Such power should start automatically in the event of power failure and shall have the ability to be sustained for a minimum of 48 hours.

j. The PSAP and 911 authorities shall make every attempt to disallow the intrusion by automatic dialers, alarm systems, or automatic dialing and announcing devices through the 911 system. If intrusion by one of these devices should occur, 911 authorities shall make every attempt to contact the responsible party to ensure there is no such further occurrence by notifying the party that knowing and intentional interference with emergency telephone calls constitutes a crime under Iowa Code section 727.5. Those responsible for PSAP operations shall report persons who repeatedly use automatic dialers, alarm systems, or automatic announcing devices through the 911 system to the county attorney for investigation of possible violations of Iowa Code section 727.5.

k. Each PSAP shall be equipped with an appropriate telecommunications device for the deaf in accordance with 28 CFR §35.162, July 3, 2025.

l. PSAPs will have the capability to access translation services to help process 911 calls from non-English speakers.

m. Each PSAP shall adhere to NENA STA-020.1-2020 as of [the effective date of this rule].

10.11(3) Originating service providers shall adhere to the following minimum requirements:

a. 911 authorities shall be notified of all service interruptions in accordance with 47 CFR Part 4 as amended to [effective date of the rulemaking].

b. The originating service provider shall respond, within a reasonable length of time, to all appropriate requests for information from 911 authorities and shall expressly comply with the provisions of Iowa Code section 34A.8.

c. Originating service providers and MLTSs must update and maintain the state ALI database with accurate information. When delivering 911 calls, caller location must be provided in compliance with 47 CFR §9.8, 47 CFR §9.10, and 47 CFR §9.15, all as amended to [effective date of this rulemaking].

d. Access to the 911 entry point and NG911 network shall be approved by the 911 program manager. Originating service providers must provide the company name, address and point of contact with their request. If the originating service provider utilizes a third-party vendor, the vendor must provide this information listing the vendor's customer's requested information.

605—10.12(34A) Waivers, variance request, and right to appeal.

10.12(1) All requests for variances or waivers shall be submitted to the 911 program manager in writing and shall contain the following information:

a. A description of the variance(s) or waiver(s) being requested.

b. Supporting information setting forth the reasons the variance or waiver is necessary.

c. A copy of the resolution or minutes of the joint 911 service board meeting that authorizes the application for a variance or waiver.

d. The signature of the chairperson of the joint 911 service board.

10.12(2) The 911 program manager may grant a variance or waiver based upon the provisions of Iowa Code chapter 34A or other applicable state law.

10.12(3) Upon receipt of a request for a variance or waiver, the 911 program manager shall evaluate the request and schedule a review within 20 working days of receipt of the request. The review shall be informal, and the petitioner may present materials, documents and testimony in support of the petitioner's request. The 911 program manager shall determine if the request meets the criteria established and shall issue a decision within 20 working days. The 911 program manager shall notify the

petitioner, in writing, of the acceptance or rejection of the petition. If the petition is rejected, such notice shall include the reasons for denial.

605—10.13(34A) Administrative hearings and appeals.

10.13(1) 911 program manager decisions regarding the acceptance or refusal of a 911 service plan, in whole or in part; the implementation of 911; and the imposition of the 911 surcharge within a specific 911 service area may be contested by an affected party.

10.13(2) Request for hearing shall be made in writing to the director within 30 days of the 911 program manager's mailing or serving of a decision and shall state the reason(s) for the request and shall be signed by the appropriate authority.

10.13(3) The director shall schedule a hearing within ten working days of receipt of the request for hearing. The director shall preside over the hearing, at which time the appellant may present any evidence, documentation, or other information regarding the matter in dispute.

10.13(4) The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.13(5) Any party adversely affected by the director's ruling may file a written request for a rehearing within 20 days of issuance of the ruling. A rehearing will be conducted only when additional evidence is available, the evidence is material to the case, and good cause existed for the failure to present the evidence at the initial hearing. The director will schedule a hearing within 20 days after the receipt of the written request. The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.13(6) Any party adversely affected by the director's ruling may file a written appeal to the director. The appeal request shall contain information identifying the appealing party, the ruling being appealed, specific findings or conclusions to which exception is taken, the relief sought, and the grounds for relief. The director shall issue a ruling regarding the matter within 90 days of the hearing. The director's ruling constitutes final agency action for purposes of judicial review.

These rules are intended to implement Iowa Code chapter 34A.

ARC 9824C

HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]

Notice of Intended Action

Proposing rulemaking related to emergency assistance and providing an opportunity for public comment

The Homeland Security and Emergency Management Department hereby proposes to rescind Chapter 11, "Emergency Assistance," Iowa Administrative Code, and to adopt a new Chapter 11 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 29C.20A and 29C.20B.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 29C.20A and 29C.20B.

Purpose and Summary

The proposed rulemaking eliminates language that is overly restrictive, repetitive of existing portions of the Iowa Code, and obsolete and shortens the chapter. It also implements and updates current practices.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 19, 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 January 14, 2026. Comments should be directed to:

Blake DeRouchey
Department of Homeland Security and Emergency Management
7900 Hickman Road, Suite 500
Windsor Heights, Iowa 50324
Phone: 515.323.4232
Email: blake.derouchey@iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 12:45 p.m.	Geode Room 7900 Hickman Road Windsor Heights, Iowa Video call link: meet.google.com/oqm-wujn-dif Or dial: (US) +1 475.277.0077 PIN: 619 998 977#
January 14, 2026 9:15 a.m.	Geode Room 7900 Hickman Road Windsor Heights, Iowa Video call link: meet.google.com/oqm-wujn-dif Or dial: (US) +1 475.277.0077 PIN: 619 998 977#

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 605—Chapter 11 and adopt the following **new** chapter in lieu thereof:

CHAPTER 11
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

Preamble

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

605—11.1(29C) Definitions.

"Bona fide residence" or *"bona fide address"* means the same as defined in Iowa Code section 321.1(6C).

"Department" means the same as defined in Iowa Code section 29C.2.

"Dwelling" or *"dwelling unit"* means the structure in which a household resides. "Dwelling" or "dwelling unit" includes permanent structures, mobile homes, manufactured homes, modular homes, fifth-wheel travel trailers, travel trailers, and motor homes in which a household resides.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10.

"Fifth-wheel travel trailer" means the same as defined in Iowa Code section 321.1(36D)*"c."*

"Home" means the pre-disaster dwelling or dwelling unit for a household.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Manufactured home" means the same as defined in Iowa Code section 435.1.

"Modular home" means the same as defined in Iowa Code section 435.1.

"Manufactured or mobile home" means the same as defined in Iowa Code section 435.1.

"Mitigation" means the same as defined in rule 605—1.2(29C).

"Motor home" means the same as defined in Iowa Code section 321.1(36D)*"d."*

"Necessary expense" means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

"Owner" means one or more persons, jointly or severally, in whom is vested all or part of the legal title to property or all or part of the beneficial ownership and a right to present use and enjoyment of the property. "Owner" includes a mortgagee in possession.

"Rent" means an amount paid to the landlord under the rental agreement.

"Safe, sanitary, and secure" means free from disaster-related health hazards.

"Serious need" means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

"Tenant" means a person or persons entitled under a rental agreement to occupy a dwelling or dwelling unit to the exclusion of others.

"Travel trailer" means the same as defined in Iowa Code section 321.1(36D)*"b."*

605—11.2(29C) Program implementation.

11.2(1) *Disaster proclamation.* The Iowa individual assistance grant program (IIAGP) shall be implemented when the governor issues a proclamation of a state of disaster emergency that authorizes individual assistance. The program shall be in effect only in those counties named in the proclamation. Assistance shall be provided for a period not to exceed 120 days from the date of proclamation.

11.2(2) *Voucher system.* The IIAGP will be implemented through a reimbursement or voucher system. Reimbursement may include checks provided to the applicant. The applicant must sign a promise to purchase replacement food or personal property.

11.2(3) *Program extensions.*

a. The program may be extended beyond 120 days through an extension of the governor's disaster proclamation; or

b. The program may be extended in 30-day intervals requested by the applicant household through the contracted entity and approved by the department.

605—11.3(29C) Application for assistance. To request assistance for disaster-related expenses, the household shall complete the online form and submit it within 45 days of the disaster proclamation to the contracted administrative entity.

11.3(1) Application forms are available from an approved administrative entity, as well as the website of the department at homelandsecurity.iowa.gov.

11.3(2) The application shall include:

a. A declaration of the household's annual income, accompanied by a current pay stub, W-2 form, or income tax return.

b. An authorization to release confidential information to personnel involved in administering the program.

c. A certification of the accuracy of the information provided.

d. An assurance that the household had no insurance coverage for claimed items.

e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.

f. A short, handwritten narrative of how the disaster event caused the claimed loss, including an itemized list of items damaged by the disaster.

g. A copy of a picture identification document for the adult applicant.

h. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

11.3(3) The application period may be extended beyond 45 days through an extension of the governor's disaster proclamation. If the forty-fifth day falls on a Saturday, Sunday, or holiday, the deadline is moved to the following business day.

11.3(4) Only one application will be accepted per household. Duplicate applications will be denied.

11.3(5) Applicants must respond to requests for information within 21 days or the application will be denied. If an application is denied because a client does not respond to a request for documentation, the applicant has 30 days from the date on the notice letter to submit documentation or the case cannot be reopened.

605—11.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

11.4(1) The household's bona fide residence was located in the area identified in the disaster proclamation during the designated incident period, and the household verifies occupancy at that

residence. If a vehicle was damaged, the vehicle must have been located in the same county as the bona fide residence.

11.4(2) Household members are citizens of the United States or are legally residing in the United States.

11.4(3) The household's annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income. Proof of income is required.

c. Income determination is based on the applicant's or applicants' adjusted gross income as defined in 26 U.S.C. §62 as amended to [effective date of the rulemaking].

11.4(4) The household has unmet disaster-related expenses or serious needs that are not covered by insurance. The applicant must provide claim documentation from the insurance company.

11.4(5) The household has not previously received assistance from this program or another program for the same loss in the same disaster.

11.4(6) Household eligibility for home repair assistance for a dwelling or dwelling unit damaged due to a proclaimed disaster is only available for a household that owns and occupies the dwelling or dwelling unit being repaired.

a. Assistance will be denied if preexisting conditions are the cause of the damage.

b. Repairs to rental dwellings, dwelling units, or landlord-owned equipment are excluded under this program.

605—11.5(29C) Eligible categories of assistance. Expenses eligible for grant funding shall be limited to personal property, food assistance, home repair and temporary housing and shall not exceed a total of $7,000. Assistance is available under the program for the following disaster-related expenses:

11.5(1) Personal property and food assistance may be issued for damage to personal property or food replacement. Eligible items for personal property assistance may include but are not limited to the following items, based on the item's condition:

a. Appliances or equipment, including:

(1) Small household appliances, including but not limited to:

1. Toasters,
2. Blenders,
3. Microwaves,
4. Vacuums,
5. Dehumidifiers, and
6. Window air conditioners.

(2) Large household appliances if the appliance is owned by the household and not a landlord.

(3) Outdoor equipment, including:

1. Lawn mowers, and
2. Snow blowers.

b. Food.

c. Personal hygiene items.

d. Prescription medications or medical equipment not covered by insurance.

e. Basic household items, including but not limited to:

(1) Furnishings (e.g., tables, chairs, dressers, couches, end tables),
(2) Beds (e.g., mattresses, bedding),
(3) Curtains or window treatments,
(4) Car or booster seats,
(5) Strollers,
(6) Storage totes,
(7) Televisions,

(8) Laptop or desktop computers, and

(9) Area rugs.

f. Clothing.

g. Short-term transportation, such as bus passes.

h. Debris removal.

i. Vehicle repair or replacement if a total loss has occurred.

j. Other personal property items, as determined by the department, in order to assist the household in making the dwelling or dwelling unit safe, sanitary, and secure.

11.5(2) Home repair assistance may be issued for home repair for an owner-occupied dwelling or dwelling unit as needed to make the dwelling or dwelling unit safe, sanitary, and secure, up to a maximum of $7,000.

a. Assistance will be denied if preexisting conditions are the cause of the damage.

b. Repairs to rental dwellings or dwelling units or landlord-owned equipment are excluded under this program.

c. Assistance may be authorized for:

(1) The repair of structural components, such as the foundation and roof.

(2) The repair of floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

(3) Mitigation measures.

(4) Debris removal, including trees.

(5) Bathroom, including toilet, sink, and tub/shower.

(6) Sump pump installation (in a flood event only).

(7) Electrical or mechanical repairs.

(8) Water heater.

(9) Heating systems.

(10) Air-conditioning systems.

(11) Water well repair for dwellings or dwelling units with no other source of water available.

(12) Water softener repair.

d. Repairs completed by a vendor must be compliant with applicable building codes and standards as of the date of the governor's proclamation.

11.5(3) Temporary housing assistance.

a. Temporary housing assistance may be issued to a household for lodging at a licensed establishment, such as a hotel or motel. The household's home must be considered to be destroyed, uninhabitable, inaccessible, or unavailable to the household. Total temporary housing assistance cannot exceed $7,000 and is included as part of disaster assistance.

b. Temporary housing assistance may also be granted for rental unit application fees, deposits, and first month's rent for a new dwelling.

11.5(4) Replacement, repair, or provision of other items of necessity may be approved by the department on a case-by-case basis, up to a maximum of $7,000.

605—11.6(29C) Eligibility determination and payment.

11.6(1) The contracted entity or designee shall confirm that the bona fide address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area. The department or contracted entity reserves the right to view the damaged property prior to providing any assistance pursuant to IIAGP.

11.6(2) Designated staff in the department shall:

a. Monitor applicants' names and addresses as reports are submitted by the administrative entity.

b. Monitor, review, and provide timely submission of invoices by the administrative entity for payment and shall process appeals.

11.6(3) For applications with a voucher or reimbursement request, the department or its designee shall:

a. Determine eligibility and the amount of payment within the rules of the program.

b. Notification of the decision will be written, timely and adequate. Timely means within ten days of the decision being made along with a full and complete explanation for why assistance may have been denied.

c. Authorize vouchers to an eligible household to purchase needed goods and services.

d. Pay vendors for goods and services purchased with vouchers.

605—11.7(29C) Contested cases.

11.7(1) *Reconsideration.*

a. The household may request reconsideration of decisions regarding eligibility and the amount of assistance awarded.

b. To request reconsideration, the household shall submit a written request to the Iowa Department of Homeland Security and Emergency Management, 7900 Hickman Road, Windsor Heights, Iowa 50324, within 30 days of the date of the letter notifying the household of the department's decision. Reconsiderations will also be accepted electronically via the process detailed in the initial notice of decision.

c. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 30 days of receipt of the request.

11.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 605—Chapter 2 and this rule.

a. Appeals must be submitted in writing to the Iowa Department of Homeland Security and Emergency Management, 7900 Hickman Road, Windsor Heights, Iowa 50324, within 30 days of the date of the reconsideration decision. Written appeals will also be accepted electronically via the process detailed in the notice of reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

605—11.8(29C) Discontinuance of program.

11.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §5121 through §5207 as of [the effective date of this rule], the Iowa individual assistance grant program administered under this chapter will be discontinued in the geographic area designated by the federal individual assistance program. Upon issuance of the presidential declaration:

a. No more applications will be accepted.

b. Any applications that are in process but are not yet approved will be denied.

c. Persons seeking assistance under this program will be advised to apply for federal disaster assistance.

11.8(2) *Exhaustion of funds.* The program will be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance will be approved on a first-come, first-served basis until all funds have been depleted. "First-come, first-served" is determined by the date the application is approved for payment.

a. Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. Reserved funds. A portion of allocated funds will be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have been awarded.

c. Untimely applications. Applications received after the program is discontinued will be denied.

These rules are intended to implement Iowa Code section 29C.20A.

605—11.9 to **11.20** Reserved.

DIVISION II
IOWA DISASTER CASE ADVOCACY

605—11.21(29C) Purpose. The purpose of these rules is to guide the provision of the Iowa disaster case advocacy (IDCA) program during the time of emergency disaster for individual assistance when a disaster is proclaimed by the governor of the state of Iowa.

605—11.22(29C) Definitions.

"Contracted entity" means an entity chosen by the department as the contracted administrator for the IDCA program.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Iowa disaster human resource council" or *"IDHRC"* is recognized as the designated voluntary organization active in disasters for Iowa.

"Necessary services" means the guidance and advice in obtaining a service, or assistance in obtaining resources from various providers for any other activity that addresses a serious need.

605—11.23(29C) Program implementation.

11.23(1) *Disaster proclamation.* The IDCA program shall be implemented when the governor issues a proclamation of a state of emergency disaster that authorizes individual assistance.

a. The program shall be in effect only in those counties named in the proclamation.

b. The program shall commence on the day following the governor's disaster proclamation and shall be provided for a period of up to 180 days from the date of proclamation.

c. The program may be extended in intervals up to 90 days when adequate justification is presented to the department, but not to exceed 730 days from the date of the proclamation.

d. If the disaster becomes a presidentially declared disaster and a Federal Emergency Management Agency (FEMA) disaster case management (DCM) grant is approved, then assistance may be provided for a period of up to 24 months from the date of the proclamation.

e. The reporting of the numbers of contacts, cases opened, cases pending, cases closed, and other reports as determined and communicated by the department.

f. Audits of disaster case files, as well as cost management and expenditures, may be randomly performed by the department without notice.

11.23(2) *Contracting.* The administrative entity currently under contract for the IIAGP may receive an amended contract to specify administration of the IDCA program.

a. Future contract renewals may be inclusive with the IIAGP and as amended to include the IDCA program.

b. If a local contracted entity is under contract with the state to provide other services or is implementing a state or federal program and the contract contains a sufficient surety bond or other adequate financial responsibility provision, the department shall accept the existing surety bond or financial responsibility provisions in lieu of applying a new or additional surety bond or financial responsibility requirement.

c. The contracted entity shall coordinate activities with emergency management coordinators and voluntary organizations active in the disaster while the program is active. The contracted entity may subcontract with other entities to provide disaster case advocacy with the approval of the department.

605—11.24(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

11.24(1) The household's residence was located in the area identified in the disaster proclamation during the designated incident period and the household verifies occupancy at that residence.

11.24(2) Household members are citizens of the United States or are legally residing in the United States.

11.24(3) The household has disaster-related needs that represent a burden that the family is unable to resolve.

605—11.25(29C) Services. Disaster case advocacy is a time-limited resource and process that involves a partnership between a case advocate and a household impacted by a disaster (also known as a client) to develop and carry out a disaster recovery plan. This partnership provides the client with a single point of contact to facilitate access to a broad range of resources, promoting sustainable assistance for individuals and a household's recovery. These services are client-focused and provided in a manner consistent with standards for trauma-informed practice in human services.

605—11.26(29C) Disaster-caused unmet needs. A disaster-caused unmet need is an unresourced item, support, or assistance that has been assessed by a representative from a local, state, tribal, federal agency or a voluntary, or faith-based organization and that is needed for the client to recover from the disaster. Unmet disaster-caused needs may also include basic and immediate needs, such as food, clothing, shelter, or first aid, and long-term needs, such as financial, physical, emotional or spiritual well-being.

605—11.27(29C) Resources. Applicable resources may include but not be limited to insurance payments, state assistance, voluntary/faith-based and local community assistance, federal disaster assistance, small business administration loans, and personal resources.

605—11.28(29C) Standards and policies.

11.28(1) *Access.* The contracted entity shall provide clients with ease of access to disaster case advocacy services.

11.28(2) *Confidentiality and duplications of benefits.*

a. The contracted entity shall have policies and procedures to meet requirements regarding maintaining confidentiality set forth by the department.

b. The contracted entity shall develop memorandums of agreement, memorandums of understanding, and release of information that will allow coordinated case advocacy and services and prevent the duplication of benefits.

11.28(3) *Engagement.* The case advocate shall create a sustainable, trusting partnership with the client.

11.28(4) *Screening.* The case advocate shall perform screening to determine eligibility and disaster-related unmet needs.

11.28(5) *Intake and assessment.* The case advocate shall perform intake and assessment procedures to triage disaster-related needs of eligible households.

a. A case advocate shall conduct an assessment specifically seeking targeted information to identify a client's disaster-related needs.

b. An assessment should focus on planning for recovery and meeting recovery goals.

c. An assessment should be conducted in person, when feasible, and should follow all standards for confidentiality and engagement.

11.28(6) *Recovery planning.*

a. A recovery plan should outline tasks for both the client and case advocate based on an assessment and documentation of needed services.

b. The plan should identify priority needs and connect the client with resources, establish benchmarks and goals to measure progress toward recovery, and outline a case closure procedure.

c. The plan should be a joint effort between the case advocate and the client.

d. The case advocate should explain the available options, the resource and recovery alternatives, and the support services offered by the case advocate.

11.28(7) *Action and advocacy.* The case advocate role in recovery includes providing, referring or arranging for needed services and resources; verifying unmet needs, completing documentation and checking duplication of benefits; and actively advocating for the client through presentation, participation in recovery groups and interface with government and nongovernment resource providers.

11.28(8) *Monitoring.* Monitoring the services allows the case advocate to keep documents up to date, to determine if the chosen resources are providing the services needed, and to evaluate whether adjustments are needed.

11.28(9) *Closure.*

a. Closure procedures should be outlined in the recovery plan and the roles and responsibilities of the client and case advocate clearly defined.

b. Case closure acknowledges the recovery goals achieved, recognizes the progress made toward unmet goals, and identifies needed resources to continue progress.

605—11.29(29C) Planning and training. Training will adhere to the disaster case management criteria, as prescribed by the federal Administration for Children and Families as of [the effective date of this rule] and follow the disaster case advocacy guidelines as designed by the IDHRC or the approved rules of the department. The department shall request from the executive council of the state of Iowa funds to perform training in disaster case advocacy as requested and necessary to prepare for disaster response.

605—11.30(29C) Payment for services.

11.30(1) The department will negotiate payment with the contracted entity when the contract is established. Payment will be based on the contracted entity's actual direct and indirect costs.

11.30(2) The department will accept the contracted entity's federally approved indirect cost rates as required by the federal Office of Management and Budget (OMB).

11.30(3) The local administrative entity may draw down grant funding to pay valid claims on at least a weekly basis.

11.30(4) Exhaustion of funds. The program shall be discontinued when the funds available for the program have been exhausted. The department will notify the contracted entity of the total available funds for the IDCA program once funds have been approved by the executive council. To ensure equitable treatment, assistance will be approved on a first-come, first-served basis until all funds have been exhausted.

605—11.31(29C) Contested cases.

11.31(1) *Reconsideration.*

a. The household may request reconsideration of decisions regarding eligibility.

b. To request reconsideration, the household shall submit a written request to the Iowa Department of Homeland Security and Emergency Management, 7900 Hickman Road, Windsor Heights, Iowa 50324, within 30 days of the date of the letter notifying the household of the contracted entity's decision. Reconsiderations will also be accepted electronically via the process detailed in the initial notice of decision.

c. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 30 days of receipt of the request.

11.31(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 605—Chapter 2 and this rule.

a. Appeals must be submitted in writing to the Iowa Department of Homeland Security and Emergency Management, 7900 Hickman Road, Windsor Heights, Iowa 50324, within 30 days of the date of the reconsideration decision. Written appeals will also be accepted electronically via the process detailed in the notice of reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

These rules are intended to implement Iowa Code section 29C.20B.

ARC 9853C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to managed care and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 73, "Managed Care," Iowa Administrative Code, and to adopt a new Chapter 73 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed 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 249A.

Purpose and Summary

This proposed chapter is the subject of a Red Tape Review pursuant to Executive Order 10. As a result of the review, the Department standardized the use of acronyms, deleted restrictive terms, and made other perfecting changes. The proposed chapter provides that most Iowa Medical Assistance Program benefits will be provided through managed care.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

This proposed rulemaking has no impact on State revenues.

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 January 13, 2026. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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.

ARC 9848C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to the Iowa health and wellness plan and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 74, "Iowa Health and Wellness Plan," Iowa Administrative Code, and to adopt a new Chapter 74 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapters 249A and 249N.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 249A and 249N.

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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

In SFY 2024, the State share of expenditures for the Iowa Health and Wellness Plan was $188,092,652.

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 January 13, 2026. 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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 exempt 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 exempt 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 exempt 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 exempt individuals.* An IHAWP member who has been determined by the department to be a medically exempt 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 may refer a member for a medically exempt 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 exempt 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.

ARC 9855C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to conditions of participation for providers of medical and remedial care and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Iowa Administrative Code, and to adopt a new Chapter 77 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed 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 249A.

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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

This proposed rulemaking has no impact on State revenues.

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 January 13, 2026. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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 TJC.

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 TJC.

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 TJC.

(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 earlier.

3. IPS teams that 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 shall 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 shall 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 SCL service. The department does not recognize individuals as service providers under the SCL 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 supported 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 department may provide living units of up to eight beds. The department 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 TJC, 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 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.

ARC 9865C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to medical and remedial services and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Iowa Administrative Code, and to adopt a new Chapter 78 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed 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 249A.

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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

Iowa Medicaid is aligning reimbursement practices for rehabilitation and speech therapy services with federal law and Centers for Medicare and Medicaid Services (CMS) guidelines. This change ensures fair, consistent billing practices and protects Medicaid program integrity while maintaining access to high-quality therapy services for members. Initial estimates from one managed care organization (MCO) indicated that State savings would be $480,000. Based on reviewing State fiscal year 2025 data, the estimated annual savings would be $2.8 million for the State.

Jobs Impact

The Department received feedback that these proposed changes could impact business, including jobs, due to the revisions in numbered paragraph 78.1(19)“a”(6)“3.”

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 January 13, 2026. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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 that 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 woman'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 that 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 that 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 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 that 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 that 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, Mallory-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 that 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 that 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 that 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.

ARC 9852C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to providers of medical and remedial care and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code, and to adopt a new Chapter 79 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 249A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 124 and 249A and Public Laws 111.5 and 109-177.

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 Medicaid Advisory Council;
- Beneficiary 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; eliminated 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 removed references to Iowa Code sections that were repealed by 2024 Iowa Acts, House File 2673.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 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 January 13, 2026. 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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

Provider category	Basis of reimbursement	Upper limit
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 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:		

Provider category	Basis of reimbursement	Upper limit
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 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-

Provider category	Basis of reimbursement	Upper limit
		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:		
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

Provider category	Basis of reimbursement	Upper limit
		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 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

Provider category	Basis of reimbursement	Upper limit
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 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%

Provider category	Basis of reimbursement	Upper limit
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
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 the payment rate must be based on 441—subparagraph 78.34(13)(2)*"g"*
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

Provider category	Basis of reimbursement	Upper limit
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
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%

Provider category	Basis of reimbursement	Upper limit
Nursing facilities: 1. Nursing facility 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—numbered paragraphs 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—numbered paragraphs 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—subparagraphs 81.5(16)*"f"*(1) and *"f"*(2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—subparagraphs 81.5(16)*"f"*(1) and *"f"*(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—numbered paragraph 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—numbered paragraph 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 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—subparagraph81.5(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—subparagraph 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%

Provider category	Basis of reimbursement	Upper limit
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%
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 paragraph 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 rule 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.	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."*

Indicator	Item, Code, or Service	OPPS Payment Status
	● Separately payable clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Separately payable nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy.	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."* 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

Indicator	Item, Code, or Service	OPPS Payment Status
		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. ● 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.

Indicator	Item, Code, or Service	OPPS Payment Status
		● 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 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 79.4(3)*"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) Medicaid 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. 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 fiscal 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 quarterly at a minimum.

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) Beneficiary advisory council. Pursuant to 42 CFR 431.12(e), Iowa Medicaid will form and support a beneficiary advisory council. The council will be governed by bylaws, which are available on the department's website.

441—79.9(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.

79.9(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.

79.9(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.9(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.

79.9(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.9(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.9(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).

79.9(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.

79.9(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.

79.9(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.

79.9(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—79.10(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.10(1) Medicare definitions and policies apply to services provided unless specifically defined differently.

79.10(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.

79.10(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.10(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.

79.10(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.

79.10(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.

79.10(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.

79.10(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—79.11(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).

79.11(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.

79.11(2) Medicaid payment will not be made to the hospital if Iowa Medicaid denies the procedure requested in the preadmission review.

79.11(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.

79.11(4) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid according to 441—Chapter 7.

79.11(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—79.12(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).

79.12(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.

79.12(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.

79.12(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.

79.12(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.

79.12(5) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid in accordance with 441—Chapter 7.

441—79.13(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:

79.13(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.

79.13(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.13(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.

79.13(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.13(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—79.14(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—79.15(249A) Provider enrollment.

79.15(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.

79.15(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.

79.15(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.

79.15(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.

79.15(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.

79.15(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.15(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.

79.15(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.15(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.

79.15(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.

79.15(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.

79.15(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.

79.15(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.

79.15(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.

79.15(15) Temporary moratoria. Iowa Medicaid must impose any temporary moratorium pursuant to Iowa Code section 249A.48.

79.15(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.15(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—79.16(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.

79.16(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.

79.16(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.

79.16(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—79.17(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.

ARC 9851C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to procedure and method of payment and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 80, "Procedure and Method of Payment," Iowa Administrative Code, and to adopt a new Chapter 80 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed 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 249A.

Purpose and Summary

This proposed rulemaking underwent a Red Tape Review in response to Executive Order 10. As a result of the review, the Department:

- Eliminated restrictive terms.
- Standardized use of acronyms.
- Added and updated dates certain.
- Referred items back to the applicable CFR or Iowa Code section.
- Removed references to the integrated health home program, which is sunsetting.
- Reordered rules.
- Referred items back to the appropriate provider manual.
- Removed references to specific form numbers.
- Eliminated references to specific areas of the Department and replaced with "Iowa Medicaid" or "the department."
- Eliminated outdated references.

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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 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 January 13, 2026. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th St.
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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6

January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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.

ARC 9856C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to Medicaid waiver services and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code, and to adopt a new Chapter 83 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed 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 249A; 2005 Iowa Acts, chapter 167, section 13; and 2005 Iowa Acts, chapter 117, section 3.

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 the Department's review, the Department deleted redundant, restrictive, and outdated language and added dates certain. The revisions in this proposed rulemaking are separate and distinct from changes the Department may make to its rules as a result of the upcoming waiver redesign process.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

This proposed rulemaking has no impact on State revenues.

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 January 13, 2026. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"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 DSM-5 or has a related condition as defined in 42 CFR 1010 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.* 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 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.* 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.* 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.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"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 DSM-5.

"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 DSM-5 or has a related condition as defined in 42 CFR 1010 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
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.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"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 DSM-5 or has a related condition as defined in 42 CFR 1010 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 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.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"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 DSM-5 or has a related condition as defined in 42 CFR 1010 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.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"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 DSM-5 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 DSM-5 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.

ARC 9854C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to fee-for-service case management and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 90, "Case Management Services," and to adopt a new Chapter 90, "Fee-for-Service Case Management," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed 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 249A.

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 (HIPP) program;
- 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); and
- 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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

This proposed rulemaking has no impact on State revenues.

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 January 13, 2026. Comments should be directed to:

Victoria L. Daniels
Department of Health and Human Services
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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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. This rule 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. This rule 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. This rule 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. This rule 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) This rule 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.

ARC 9845C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to protective locked environment for certain children and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to amend Chapter 105, "Juvenile Detention and Shelter Care Homes," Chapter 106, "Certification Standards for Children's Residential

Facilities," Chapter 114, "Licensing and Regulation of All Group Living Foster Care Facilities for Children," and Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 237C and 2025 Iowa Acts, Senate File 474.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 237C and 2025 Iowa Acts, Senate File 474.

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 protective locked environment for certain children.

Proposed references to Iowa Code section 237.1(8A) are to that section as enacted by Senate File 474.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 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 January 13, 2026. 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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** 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.

ARC 9846C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to kinship foster care approval standards and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to adopt new Chapter 125, "Kinship Foster Care Approval Standards," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 237 and 2025 Iowa Acts, Senate File 641.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 237 and 2025 Iowa Acts, Senate File 641.

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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 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 January 13, 2026. 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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** 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. There is just cause due to a condition or combination of conditions that cannot be improved and prevents 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 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.

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 those 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.

441—125.12(237) Liability. Kinship foster caregivers who apply the reasonable and prudent parent standard reasonably and in good faith in regard to the child(ren) placed in their home shall have

immunity from civil or criminal liability that might otherwise be incurred or imposed. This rule shall not remove or limit any existing liability protection afforded under any other law.

These rules are intended to implement Iowa Code chapter 237 and section 234.40.

ARC 9847C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to juvenile court-ordered services and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to rescind Chapter 151, "Juvenile Court Services Directed Programs," and to adopt a new Chapter 151, "Juvenile Court-Ordered Services," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 232.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 232.

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 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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 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 January 13, 2026. 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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 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.

ARC 9844C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rulemaking related to opioid settlement fund disbursement and providing an opportunity for public comment

The Department of Health and Human Services hereby proposes to adopt new Chapter 306, "Opioid Settlement Fund Disbursement," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 12.51 and 2025 Iowa Acts, House File 1038.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 12.51 and 2025 Iowa Acts, House File 1038.

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.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on November 12, 2025. A public hearing was held on the following date(s):

- December 2, 2025

Fiscal Impact

Division II of the Act provided a supplement appropriation of $29 million. Following that, it is estimated that the Department will receive the following amounts of funds for disbursement: FY 2026, $28,611,794; FY 2027, $7,433,269; FY 2028, $5,590,470; FY 2029, $8,011,520; and FY 2030, $8,212,828.

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 January 13, 2026. 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:

January 13, 2026 10 to 10:30 a.m.	Microsoft Teams Meeting ID: 215 699 055 154 00 Passcode: m6GB6cj6
January 13, 2026 2 to 2:30 p.m.	Microsoft Teams Meeting ID: 247 965 039 141 20 Passcode: KU3Uu7ct

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** 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(2)*"b"*(3)(d).

These rules are intended to implement Iowa Code section 12.51 as amended by 2025 Iowa Acts, House File 1038.

ARC 9826C

IOWA FINANCE AUTHORITY[265]

Notice of Intended Action

Proposing rulemaking related to military service member home ownership assistance program and providing an opportunity for public comment

The Iowa Finance Authority hereby proposes to rescind Chapter 27, "Military Service Member Home Ownership Assistance Program," Iowa Administrative Code, and to adopt a new Chapter 27 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 16.5.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 16.54.

Purpose and Summary

Pursuant to Executive Order 10, the Authority proposes to rescind Chapter 27 and adopt a new chapter in lieu thereof. The proposed chapter eliminates language that is duplicative of statutory language, eliminates unnecessary and inconsistent language, removes unnecessarily restrictive terms, and updates outdated language. The proposed chapter also specifies the amount of the annual application fee for facilitating lenders and updates an Authority website reference.

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 Authority for a waiver of the discretionary provisions, if any, pursuant to 265—Chapter 18.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Authority no later than 4:30 p.m. on January 15, 2026. Comments should be directed to:

Tyler Barnard
Iowa Finance Authority
1963 Bell Avenue, Suite 200

Des Moines, Iowa 50315
Email: tyler.barnard@iowafinance.com

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 to 9:15 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-finance-authority/ifa-red-tape-review
January 15, 2026 9 to 9:15 a.m.	Via Microsoft Teams Information about Teams participation can be found at opportunityiowa.gov/about/iowa-finance-authority/ifa-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 265—Chapter 27 and adopt the following **new** chapter in lieu thereof:

CHAPTER 27
MILITARY SERVICE MEMBER HOME OWNERSHIP ASSISTANCE PROGRAM

265—27.1(16) Purpose. The purpose of the military service member home ownership assistance program is to help eligible members of the armed forces of the United States to purchase qualified homes in Iowa.

265—27.2(16) Definitions. As used in this chapter, unless the context otherwise requires:

"Closing agent" means the attorney, real estate firm, or closing company that is closing the qualifying purchase transaction and that prepares the cash sale settlement statement.

"Eligible service member" means the same as defined in Iowa Code section 16.54.

"Facilitating lender" means a lender that is not a participating lender but that is approved by the authority to make loans under the military home ownership assistance program pursuant to Iowa Code section 16.54(5) and subrule 27.3(7).

"Home ownership assistance" means the one-time assistance of up to $5,000 per eligible service member that may be used toward down payment or closing costs, or both, in the purchase of a qualified home.

"Manufactured home" means the same as defined in Iowa Code section 435.1.

"Participating lender" means a lender approved for participation in one or more of the authority's first mortgage financing home buyer programs. The authority maintains a list of participating lenders on its website: www.welcomehomeia.com/find-lender-realtor.

"Program," "military home ownership assistance program" or *"MHOA"* means the military service member home ownership assistance program authorized by Iowa Code section 16.54.

"Qualified home" means a home located in the state of Iowa that an eligible service member purchases, occupies, and uses as the service member's primary residence that is one of the following:

1. Single-family residence, including "stick-built" homes, modular homes, or manufactured homes;
2. Condominium;
3. Townhome;
4. A property containing two to four residential units, where one unit is to be occupied by the eligible service member as the service member's primary residence.

"Qualified mortgage" means a permanent mortgage loan made pursuant to one of the authority's home buyer mortgage programs unless the lender offers financing that is more financially advantageous for the service member.

"Status documentation" means written documentation verifying that the applicant is an eligible service member. This documentation may include but is not limited to a copy of a valid DD Form 214, showing character of service other than dishonorable, or the applicant's most recent leave and earnings statements representing 90 days of active duty.

"Title guaranty certificate" means the certificate issued by the Iowa title guaranty division of the authority pursuant to Iowa Code section 16.91 to ensure marketable title to the lender or the homeowner, or both.

265—27.3(16) Application procedure and determination of eligibility.

27.3(1) *Prior approval.* Whether the purchase of a qualified home is by mortgage financing or cash, prior approval of the assistance by the authority is required. Approval of the request will include supporting document review by the authority and a determination of the service member's eligibility by the Iowa department of veterans affairs.

27.3(2) *Financed home purchases.*

a. Where a qualified home purchase is financed, the eligible service member is to apply for assistance under the program through a participating or facilitating lender. If the service member qualifies for one of the authority's home buyer mortgage programs, the mortgage financing provided is to be a qualified mortgage. Service members who are not eligible for one of the authority's home buyer mortgage programs and are not purchasing on a cash basis may use any permanent financing available to them.

b. To apply for assistance, eligible service members provide the participating or facilitating lender with status documentation and all necessary program documents.

c. Once the lender receives all necessary information under this subrule, the lender is to transmit copies of the necessary documentation to the authority.

27.3(3) *Cash home purchases.* For a cash purchase of a qualified home, the eligible service member provides the authority with:

a. Status documentation;

b. The purchase agreement; and

c. A title guaranty commitment.

27.3(4) *Referral of status documentation to Iowa department of veterans affairs.* The authority submits status documentation to the Iowa department of veterans affairs for verification that an applicant is an eligible service member. The Iowa department of veterans affairs is the final authority on whether an applicant is an eligible service member.

27.3(5) *Notice of MHOA approval.* Once the Iowa department of veterans affairs confirms an applicant's eligibility, the authority notifies the lender, or eligible service member in the case of a cash purchase, that the MHOA application is approved.

27.3(6) *Gaps in funding.* Where military assistance funds are unavailable during the home purchase process, MHOA requests may be placed on a waiting list. When funds become available after the home purchase closed without military assistance funds being applied toward closing costs or down payment, MHOA proceeds will be paid (1) directly to the participating lender or servicing lender to be applied toward the qualified mortgage loan's principal balance, or (2) if the qualified home was purchased

pursuant to a cash purchase transaction, directly to the eligible service member. The authority will notify the applicant that MHOA proceeds will be applied to the principal balance.

27.3(7) *Approval process for facilitating lender status.* Pursuant to Iowa Code section 16.54(5), an Iowa-regulated or federally regulated lender with a physical location in the state of Iowa may submit an application to the authority for approval, even if such lender does not participate in the authority's home ownership programs for home buyers. The approval to be a facilitating lender is valid for one year. Lenders are to submit an application and application fee of $1,500 annually. Application fees are not charged in part or in full to a service member or to a property seller.

265—27.4(16) MHOA award. Assistance awarded hereunder is up to $5,000 and is applied toward a qualified home purchase.

27.4(1) *MHOA reimbursement.* The lender advances funds at closing in an amount equal to the assistance on behalf of the eligible service member.

a. After closing, the lender submits copies of the following documents to the authority:

(1) An executed settlement statement;
(2) The deed conveying title;
(3) A title guaranty commitment;
(4) The promissory note; and
(5) The mortgage.

b. After closing, for cash home purchasers, the eligible service member shall submit copies of the following documents to the authority:

(1) The executed settlement statement;
(2) The deed conveying title; and
(3) The executed title guaranty certificate.

27.4(2) *MHOA assistance conditions.* All assistance under the program is subject to funding availability. Assistance will be awarded in the order in which all required documentation is received and approved by the authority. Assistance awarded pursuant to the program is personal to its recipient and nonassignable. A maximum of one assistance award is awarded per home purchase. If both homeowners are eligible service members, only one may use the MHOA per home purchase. If another home is subsequently purchased, the other eligible service member may use the MHOA on the second home if the program exists and funds are available. An eligible service member is to receive only one award under the program. While program funds are available, the award is valid for 60 days in the case of purchases of existing or completed property and 120 days in the case of purchases of property being constructed or renovated. A reasonable extension may be granted with evidence of a purchase loan in progress that has been delayed due to circumstances beyond the service member's control.

These rules are intended to implement Iowa Code sections 16.5(1)*"r"* and 16.54.

ARC 9803C

RACING AND GAMING COMMISSION[491]

Notice of Intended Action

Proposing rulemaking related to organization and operation and providing an opportunity for public comment

The Racing and Gaming Commission hereby proposes to amend Chapter 1, "Organization and Operation," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 99D.7 and 99F.4.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 99D and 99F.

Purpose and Summary

This proposed rulemaking increases the required fees for a racing, gambling structure, or excursion gambling boat license application to coincide with actual costs incurred by the Commission during the application process.

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

A representative of the Iowa Gaming Association attended the hearing and spoke in support of this amendment.

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 Commission for a waiver of the discretionary provisions, if any, pursuant to 491—Chapter 1.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Barb Blake
Iowa Racing and Gaming Commission
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321
Email: barb.blake@iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 a.m.	Commission Office 6200 Park Avenue, Suite 100 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 Commission 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 subrule 1.5(1) as follows:

1.5(1) *Racing, gambling structure, or excursion gambling boat license application.* This form ~~shall contain~~ contains at a minimum the full name of the applicant, all ownership interests, balance sheets and profit-and-loss statements for three fiscal years immediately preceding the application, pending legal action, location and physical plant of the facility, and description of proposed operation. The form may include other information the commission deems necessary to make a decision on the license application. The ~~qualified nonprofit corporation and the boat operator, if different than the qualified nonprofit corporation, shall pay a nonrefundable application fee in the amount of $25,000 to offset the commission's cost for processing the application. Additionally, the applicant shall remit an investigative fee of $30,000 to the department of public safety to do background investigations as required by the commission. The department of public safety shall bill the applicant/licensee for additional fees as appropriate and refund any unused portion of the investigative fee within 90 days after the denial or operation begins.~~ applicant or applicants also pay or remit the following fees:

a. An initial application fee in the amount of $250,000 to the commission to cover the commission's actual expenses incurred in processing and evaluating the application. Actual expenses may include but are not limited to the cost of appropriate meeting spaces, facilities, and equipment; transportation, lodging, meals, and other travel-related expenses; market feasibility studies the commission conducts; or consultants the commission retains. The commission will bill the applicant or licensee for additional expenses beyond the initial application fee as appropriate and will refund any unused portion of the fee within 90 days after the license is denied or within 90 days after operation begins.

b. An investigative fee of $50,000 to the department of public safety to complete background investigations. The department of public safety will bill the applicant or licensee for additional fees as appropriate and will refund any unused portion of the investigative fee within 90 days after the license is denied or within 90 days after operation begins.

ARC 9800C

RACING AND GAMING COMMISSION[491]

Notice of Intended Action

Proposing rulemaking related to greyhound racing and providing an opportunity for public comment

The Racing and Gaming Commission hereby proposes to rescind Chapter 7, "Greyhound Racing," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 7A and sections 99D.7, 99D.9B, 99D.23, and 99D.25 and Executive Order 10.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 99D and Executive Order 10.

Purpose and Summary

Chapter 7 sets requirements and standards for greyhound racing and greyhound racetracks. However, live greyhound racing has not occurred in Iowa since 2022 and the Commission is not aware of any licensed racetrack in Iowa that plans to resume it. Therefore, Chapter 7 is no longer necessary.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 2025

No comments were received.

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 Commission for a waiver of the discretionary provisions, if any, pursuant to 491—Chapter 1.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Barb Blake
Iowa Racing and Gaming Commission
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321
Email: barb.blake@iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 a.m.	Commission Office 6200 Park Avenue, Suite 100 Des Moines, Iowa
January 13, 2026 2 p.m.	Commission Office 6200 Park Avenue, Suite 100 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 Commission 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 **491—Chapter 7**.

ARC 9801C

RACING AND GAMING COMMISSION[491]

Notice of Intended Action

Proposing rulemaking related to pari-mutuel wagering, simulcasting and advance deposit wagering and providing an opportunity for public comment

The Racing and Gaming Commission hereby proposes to rescind Chapter 8, "Pari-Mutuel Wagering, Simulcasting and Advance Deposit Wagering," Iowa Administrative Code, and to adopt a new Chapter 8 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 99D.7, 99D.9A, 99D.9C, 99D.9D, 99D.11, and 99D.15 and Executive Order 10.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 99D and Executive Order 10.

Purpose and Summary

In accordance with Executive Order 10, the Commission proposes to rescind Chapter 8 and adopt a new chapter in lieu thereof. Chapter 8 provides details and parameters for pari-mutuel wagering, simulcasting, advance deposit wagering, and alternative simulcast operators. The Commission is reviewing rules related to racing before 2026 to make repromulgated rules effective in time for the 2026 racing season, which is scheduled to start in May.

The proposed rulemaking repromulgating Chapter 8 eliminates some outdated language; eliminates some definitions or other language that duplicated a statute; and avoids potentially conflicting standards for different types of online operators by making advance deposit wagering account registration subject to the same requirements as advance deposit sports wagering account registration.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 2025

No comments were received.

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 Commission for a waiver of the discretionary provisions, if any, pursuant to 491—Chapter 1.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Barb Blake
Iowa Racing and Gaming Commission
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321
Email: barb.blake@iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 a.m.	Commission Office 6200 Park Avenue, Suite 100 Des Moines, Iowa
January 13, 2026 2 p.m.	Commission Office 6200 Park Avenue, Suite 100 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 Commission 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 491—Chapter 8 and adopt the following **new** chapter in lieu thereof:

CHAPTER 8
PARI-MUTUEL WAGERING, SIMULCASTING AND ADVANCE DEPOSIT WAGERING

491—8.1(99D) Definitions. As used in this chapter, unless the context otherwise requires, the following definitions apply:

"Account" means an account approved by the commission for pari-mutuel advance deposit wagering with a complete record of credits, wagers and debits established by a licensee account holder and managed by a licensee or advance deposit wagering operator (ADWO).

"Administrator" means the administrator of the Iowa racing and gaming commission or the administrator's designee.

"Advance deposit wagering center" means an actual location, the equipment, and the staff of a licensee, ADWO, or both involved in the management, servicing and operation of the pari-mutuel advance deposit wagering for the licensee.

"Alternative simulcast operator" or *"ASO"* means an entity licensed by the commission to provide a system of pari-mutuel wagering at off-track betting venues at facilities licensed by the commission to conduct gambling games in Iowa.

"Authorized receiver" means a receiver that conducts and operates a pari-mutuel wagering system on the results of contests being held or conducted and simulcast from the enclosures of one or more host facilities.

"Betting interest" means a number assigned to a single runner, an entry or a field for wagering purposes.

"Board" means, as appropriate, either the board of stewards or the gaming board as defined in 491—Chapter 4.

"Breakage" means the same as defined in Iowa Code section 99D.2(2) and consists of the net pool minus payoff.

"Commission representative" means an employee of the commission designated to represent the commission in matters pertaining to the operation of the mutuel department. In the absence of a specifically appointed representative, a commission steward will perform the functions and duties of the commission representative.

"Contest" means a race on which wagers are placed.

"Credits" means all positive inflows of money to an account.

"Dead heat" means that two or more runners have tied at the finish line for the same position in the order of finish.

"Debits" means all negative outflow of money from an account.

"Deposit" means a payment of money into an account.

"Double" means a wager to select the winners of two consecutive races that is not a parlay, that has no connection with or relation to any other pool conducted by the facility, and that will not be construed as a quinella double.

"Entry" means two or more runners are coupled in a contest because of common ties and a wager on one of them is a wager on all of them.

"Exacta" (may also be known as "perfecta" or "correcta") means a wager selecting the exact order of finish for first and second in that contest and is not a parlay and has no connection with or relation to any other pool conducted by the facility.

"Field" means when the individual runners competing in a contest exceed the numbering capacity of the totalizator and all runners of the higher number are grouped together. A wager on one in the field is a wager on all.

"Guest facility" means a facility that offers licensed pari-mutuel wagering on contests conducted by another facility (the host) in either the same state or another jurisdiction.

"Host facility" means the facility where a licensed pari-mutuel meeting takes place, from which authorized contests or entire performances are simulcast.

"Interstate simulcasting" means the telecast of live audio and visual signals of pari-mutuel racing sent to or received from a state outside the state of Iowa to an authorized racing or gaming facility for the purpose of wagering. For the purposes of this definition, "interstate" also includes foreign jurisdictions.

"Intrastate simulcasting" means the telecast of live audio and visual signals of pari-mutuel racing conducted on a licensed pari-mutuel track within Iowa sent to or received from an authorized pari-mutuel facility within Iowa for the purpose of pari-mutuel wagering.

"Licensee account holder" means any individual at least 21 years of age who successfully completed an application and for whom the licensee or ADWO has opened an account. "Licensee account holder" does not include any corporation, partnership, limited liability company, trust, estate or other formal or nonformal entity.

"Minus pool" means when the total amount of money to be returned to the public exceeds what is in the pool because of the deduction of a commission and because of the rule stipulation that no mutuel tickets will be paid at less than $1.05 for each $1 wagered.

"Mutuel department" means that area of a racetrack where wagers are made and winning tickets are cashed and where the totalizator is installed and any area used directly in the operation of pari-mutuel wagering.

"Mutuel manager" means an employee of the facility who manages the mutuel department.

"Net pool" means the amount remaining in each separate pari-mutuel pool after the takeout percentage, as provided for by Iowa Code section 99D.11, has been deducted.

"Odds" means the approximate payoffs per dollar based on win pool wagering only on each betting interest for finishing first without a dead heat with another betting interest.

"Official" means that the order of finish for the race is official and that payoff prices based upon the official order of finish will be posted.

"Order of finish" means the finishing order of each runner from first place to last place in each race. For horse racing only, the order of finish may be changed by the stewards for a rule infraction prior to posting of the official order of finish.

"Pari-mutuel pool" means the total amount of money wagered on each separate pari-mutuel pool for payoff purposes.

"Payoff" means the amount distributed to holders of valid winning pari-mutuel tickets in each pool as determined by the official order of finish and includes the amount wagered and profit.

"Place" means a runner finishing second.

"Place pool" means the total amount of money wagered on all betting interests in each race to finish first or second.

"Post time" means the scheduled starting time for a contest.

"Proper identification" means a form of identification accepted in the normal course of business to establish that the person making a transaction is a licensee account holder.

"Quinella" means a wager selecting two runners to finish first and second, regardless of the order of finish, that is not a parlay and has no connection with or relation to any other pool conducted by the facility.

"Quinella double" means a wager that consists of selecting the quinella in each of two designated contests and is an entirely separate pool from all other pools and has no connection with or relation to any other pool conducted by the facility.

"Runner" means each entrant in a contest, designated by a number as a betting interest.

"Sales transaction data" means the data between totalizator ticket-issuing machines and the totalizator central processing unit for the purpose of accepting wagers and generating, canceling and cashing pari-mutuel tickets and the financial information resulting from the processing of sales transaction data, such as handle.

"Secure personal identification code" means an alpha-numeric character code provided by a licensee account holder as a means by which the licensee or ADWO may verify a wager or account transaction as authorized by the licensee account holder.

"Show" means a runner finishing third.

"Show pool" means the total amount of money wagered on all betting interests in each contest to finish either first, second or third.

"Source market fee" or *"host fee"* means the part of a wager that is made on any race by a person who is a licensee account holder and that is returned to the licensee and the Iowa Horsemen's Benevolent and Protective Association pursuant to the terms of a negotiated agreement as required by rule 491—8.6(99D).

"Steward" means a racing official appointed or approved by the commission to perform the supervisory and regulatory duties relating to pari-mutuel racing.

"Superfecta" means a wager selecting the exact order of finish for first, second, third, and fourth in that contest that is not a parlay and has no connection with or relation to any other pool conducted by the facility.

"Totalizator" means a machine for registering wagers and computing odds and payoffs based upon data supplied by each pari-mutuel ticket-issuing machine.

"Trifecta" means a wager selecting the exact order of finish for first, second, and third in that race that is not a parlay and has no connection with or relation to any other pool conducted by the facility.

"Tri-superfecta" means a wager selecting the exact order of finish for first, second and third in the first designated tri-super contest combined with selecting the exact order of finish for first, second, third and fourth in the second designated tri-super contest.

"Twin quinella" means a wager in which the bettor selects the first two finishers, regardless of order, in each of two designated contests. Each winning ticket for the twin quinella must be exchanged for a free ticket on the second twin quinella contest in order to remain eligible for the second-half twin quinella pool.

"Twin superfecta" means a wager in which the bettor selects the first four finishers, in their exact order, in each of two designated contests. Each winning ticket for the first twin superfecta contest must be exchanged for a free ticket on the second twin superfecta contest in order to remain eligible for the second-half twin superfecta pool.

"Twin trifecta" means a wager in which the bettor selects the three runners that will finish first, second, and third in the exact order as officially posted in each of the two designated twin trifecta races.

"Underpayment" means when the payoff to the public resulting from errors in calculating pools and errors occurring in the communication in payoffs results in less money returned to the public than is actually due.

"Win" means a runner finishing first.

"Win pool" means the total amount wagered on all betting interests in each contest to finish first.

"Withdrawal" means a payment of money from an account by the licensee or ADWO to the licensee account holder when properly requested by the licensee account holder.

491—8.2(99D) General.

8.2(1) *Wagering.* Each facility must conduct wagering in accordance with applicable laws and these rules, employing a pari-mutuel system approved by the commission. The totalizator should be tested prior to and during the meeting as required by the commission. Annually, the facility will have an external audit, approved by the administrator, of the totalizator system. All systems of wagering other than pari-mutuel, such as bookmaking and auction-pool selling, are prohibited, and any person attempting to participate in prohibited wagering will be ejected or excluded from facility grounds.

8.2(2) *Records.* The facility must maintain records of all wagering so the commission may review such records for any contest including the opening line, subsequent odds fluctuation, the amount and at which window wagers were placed on any betting interest, and such other information as may be required. Such wagering records will be retained by each facility for a period of time specified by the commission. The commission may require certain records to be made available to the wagering public at the completion of each contest. The facility must provide the commission with a list of the licensed individuals afforded access to pari-mutuel records and equipment at the wagering facility.

8.2(3) *Pari-mutuel tickets.* A pari-mutuel ticket is evidence of a contribution to the pari-mutuel pool operated by the facility and is evidence of the facility's obligation to pay to the holder thereof such portion of the distributable amount of the pari-mutuel pool as is represented by such valid pari-mutuel ticket. The facility cashes all valid winning tickets when presented for payment during the course of the meeting where sold and for a specified period after the last day of the meeting as provided in paragraph 8.2(4)*"g."*

a. A valid pari-mutuel ticket must have been issued by a pari-mutuel ticket machine operated by the facility, have been recorded as a ticket entitled to a share of the pari-mutuel pool, and contain imprinted information as to:

(1) The name of the facility operating the meeting.

(2) A unique identifying number or code.

(3) Identification of the terminal at which the ticket was issued.

(4) A designation of the performance for which the wagering transaction was issued.

(5) The contest number for which the pool is conducted.

(6) The type(s) of wagers represented.

(7) The number(s) representing the betting interests for which the wager is recorded.

(8) The amount(s) of the contributions to the pari-mutuel pool or pools for which the ticket is evidence.

b. No pari-mutuel ticket recorded or reported as previously paid, canceled, or nonexistent may be deemed a valid pari-mutuel ticket by the facility. The facility may withhold payment and refuse to cash any pari-mutuel ticket deemed not valid, except as provided in paragraph 8.2(4)*"e."*

8.2(4) *Pari-mutuel ticket sales.*

a. Pari-mutuel tickets cannot be sold by anyone other than a facility licensed to conduct pari-mutuel wagering.

b. No pari-mutuel ticket may be sold on a contest for which wagering has already been closed, and no facility is responsible for ticket sales entered into but not completed by issuance of a ticket before the totalizator is closed for wagering on such contest.

c. Claims pertaining to a mistake on an issued or unissued ticket must be made by the bettor prior to leaving the seller's window.

d. Payment on winning pari-mutuel wagers will be made on the basis of the order of finish as purposely posted and declared "official." Any subsequent change in the order of finish or award of purse money(s) as may result from a subsequent ruling by the stewards or administrator will not affect the pari-mutuel payoff. If an error in the posted order of finish or payoff figures is discovered, the official order of finish or payoff prices may be corrected and an announcement concerning the change will be made to the public.

e. The facility cannot satisfy claims on lost, mutilated, or altered pari-mutuel tickets without authorization from the administrator.

f. The facility has no obligation to enter a wager into a betting pool if unable to do so due to equipment failure.

g. Payment on valid pari-mutuel tickets will be made only upon presentation and surrender to the facility where the wager was made within 60 days following the close of the meeting during which the wager was made. Failure to present any such ticket within 60 days waives the right to receive payment.

8.2(5) *Claims for payment from pari-mutuel pool.* At a designated location, a written, verified claim for payment from a pari-mutuel pool will be accepted by the facility in any case where the facility has withheld payment or has refused to cash a pari-mutuel wager. The claim should be made on a form approved by the administrator and the claim attested to under penalty of perjury. The original of the claim will be forwarded to the administrator within 48 hours.

a. If a claim is made for payment of a mutilated pari-mutuel ticket that does not contain the total imprinted elements required in paragraph 8.2(3)*"a,"* the facility will include a recommendation whether or not the mutilated ticket has sufficient elements to be positively identified as a winning ticket on the claim forwarded to the administrator.

b. When a claim is made for payment on a pari-mutuel wager, the administrator will adjudicate the claim and may order payment thereon from the pari-mutuel pool or by the facility, may deny the claim, or may make such other order as the administrator may deem proper.

8.2(6) *Payment for errors.* If an error occurs in the payment amounts for pari-mutuel wagers that are cashed or entitled to be cashed, and as a result of such error the pari-mutuel pool involved in the error is not correctly distributed among winning ticket holders, the following apply:

a. Verification is required to show that the amount of the commission, the amount in breakage, and the amount in payoffs are equal to the total gross pool. If the amount of the pool is more than the amount used to calculate the payoff, the underpayment will be added to the corresponding pool of the next contest. If an underpayment is discovered after the close of the meeting, the underpayment should be held in an interest-bearing account approved by the administrator until being added, together with accrued interest, to the corresponding pool of the next meet.

b. Any claim not filed with the facility within 30 days, inclusive of the date on which the underpayment was publicly announced, is waived, and the facility has no further liability therefor.

c. In the event the error results in an overpayment to winning wagers, the facility is responsible for such payment.

8.2(7) *Public notice.* Wagering rules, betting explanations relative to each time of pool offered, approximate odds, and the calculation of payoffs and distribution of pools approved by the commission must be readily available to the public. Signage may be conspicuously posted in the wagering area to direct patrons to the wagering area where this information can be viewed. The approximate odds for win pool betting and the probable payoff or amounts wagered, in total and on each betting interest, for other pools will be displayed to the wagering public at intervals and in a manner approved by the administrator. Official results and payoffs must be publicly displayed upon each contest being declared official.

8.2(8) *Canceled contests.* If a contest is canceled or declared "no contest," refunds will be granted on valid wagers in accordance with these rules.

8.2(9) *Refunds.*

a. Notwithstanding other provisions of these rules, refunds of the entire pool are made on:

(1) Win pools, exacta pools, and first-half double pools offered in contests in which the number of betting interests has been reduced to fewer than two.

(2) Place pools, quinella pools, trifecta pools, first-half quinella double pools, first-half twin quinella pools, first-half twin trifecta pools, and first-half tri-superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than three.

(3) Show pools, superfecta pools, and first-half twin superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than four.

b. Authorized refunds are paid upon presentation and surrender of the affected pari-mutuel ticket.

8.2(10) *Coupled entries and mutuel fields.*

a. Contestants coupled in wagering as a coupled entry or mutuel field are considered part of a single betting interest for the purpose of price calculations and distribution of pools. Should any contestant in a coupled entry or mutuel field be officially withdrawn or scratched, the remaining contestants in that coupled entry or mutuel field remain valid betting interests and no refunds will be granted. If all contestants within a coupled entry or mutuel field are scratched, then tickets on such betting interests will be refunded, notwithstanding other provisions of these rules.

b. For the purpose of price calculations only, coupled entries and mutuel fields will be calculated as a single finisher, using the finishing position of the leading contestant in that coupled entry or mutuel field to determine order of placing. This rule applies to all circumstances, including situations involving a dead heat, except as otherwise provided by these rules.

8.2(11) *Pools dependent upon betting interests.* Unless the administrator otherwise provides, at the time the pools are opened for wagering, the facility:

a. May offer win, place, and show wagering on all contests.

b. May disallow show wagering on any contest with five or fewer betting interests scheduled to start.

c. May disallow place wagering on any contest with four or fewer betting interests scheduled to start.

d. May disallow quinella wagering on any contest with three or fewer betting interests scheduled to start.

e. May disallow quinella double wagering on any contests with three or fewer betting interests scheduled to start.

f. May disallow exacta wagering on any contest with three or fewer betting interests scheduled to start.

g. May disallow trifecta wagering on any contest with five or fewer betting interests scheduled to start. In addition, the stewards have the authority to cancel trifecta wagering at any time they determine an irregular pattern of wagering or determine that the conduct of the race would not be in the interest of the regulation of the pari-mutuel wagering industry or in the public confidence in racing. The stewards may approve smaller fields for trifecta wagering if extraneous circumstances are shown by the facility.

h. May disallow superfecta and pentafecta wagering on any contest with seven or fewer betting interests scheduled to start.

i. May disallow twin quinella wagering on any contests with three or fewer betting interests scheduled to start.

j. May disallow twin trifecta wagering on any contests with seven or fewer betting interests scheduled to start, except as provided in subparagraph 8.2(13)*"g"*(1).

k. May disallow tri-superfecta wagering on any contests with seven or fewer betting interests scheduled to start.

l. May disallow twin superfecta wagering on any contests with seven or fewer betting interests scheduled to start.

8.2(12) *Prior approval for betting pools.*

a. A facility that desires to offer new forms of wagering must apply in writing to the administrator and receive written approval prior to implementing the new betting pool.

b. The facility may suspend previously approved forms of wagering with the prior approval of the administrator. Any carryover is held until the suspended form of wagering is reinstated. A facility may request approval of a form of wagering or separate wagering pool for specific requirements.

8.2(13) *Closing of wagering in a contest.*

a. All wagering stops and all pari-mutuel machines are automatically locked at post time or at the actual start of the races.

b. The facility will maintain, in good order, a system approved by the administrator for closing wagering.

8.2(14) *Facility/vendor employees.* All facility/vendor employees must report immediately to the administrator any known irregularities or wrongdoings by any person involving pari-mutuel wagering and cooperate in subsequent investigations.

8.2(15) *Unrestricted access.* The facility must permit the commission unrestricted access at all times to its facilities and equipment and to all books, ledgers, accounts, documents and records of the facility that relate to pari-mutuel wagering.

8.2(16) *Totalizator breakdown.* In the event of irreparable breakdown of the totalizator during the wagering on a race, the wagering on that race will be declared closed and the payoff will be computed on the sums wagered in each pool up to the time of the breakdown.

8.2(17) *Minimum wager and payoff.* The minimum wager to be accepted by any licensed facility for win, place and show wagering is $2. The minimum payoff on a $2 wager is $2.10. For all other wagers, the minimum wager to be accepted by any licensed facility is $1. The minimum payoff for a $1 wager is $1.05. Any deviation from these minimums must be approved by the administrator. In cases where a minus pool occurs, the facility is responsible for the payment of the minimum payoff and no breakage will be incurred from that pari-mutuel pool.

8.2(18) *Underage wagering prohibited.* No licensed operator may permit any person under the age of 21 to purchase or cash a pari-mutuel ticket.

8.2(19) *Emergency situations.* In the event of an emergency in connection with the mutuel department not covered in these rules, the pari-mutuel manager representing the facility should report the problem to the stewards, and the stewards will render a full report to the administrator or administrator's designee within 48 hours.

8.2(20) *Commission mutuel representative.* The administrator may appoint an employee to serve as the commission's designated representative at each race meeting as provided in Iowa Code section 99D.19. In the absence of a specifically appointed representative, the board of stewards or simulcast steward will perform the functions and duties of the commission.

491—8.3(99D) Approval of pari-mutuel wagers.

8.3(1) *Pools permitted.* All pari-mutuel wagering pools approved by the commission are to be separately and independently calculated and distributed. Takeout is deducted from each gross pool as stipulated by Iowa Code section 99D.11. The remainder of the moneys in the pool will constitute the net pool for distribution as payoff on winning wagers.

8.3(2) *Pari-mutuel wagering submissions.* Prior to conducting a new pari-mutuel wager, a facility must submit written proposals for the wager, including but not limited to the wager type, calculation of payoff, refunds and distribution of pools. Proposals must be approved by the administrator or an administrator's designee prior to implementation.

491—8.4(99D) Simulcast wagering.

8.4(1) *General.*

a. Rules. All simulcasting must be transmitted live, and all wagering on simulcasting must be made in accordance with commission rules on pari-mutuel wagering. Commission rules in effect during live racing remain in effect during simulcasting where applicable.

b. Transmission. The method used to transmit sales transaction and data including but not limited to the odds, will pay, race results, and payoff prices must be approved by the commission, based upon the determination that provisions to secure the system and transmission are satisfactory. If the method relies on internet service to transmit, a backup internet service should be used in the event of transmission failure until all transactions are completed for the day.

c. Communication. A communication system between the host track and the receiving facility that will allow the totalizator operator and the commission representatives at the host track to communicate with the facility receiving the signal must be provided. The facility is responsible during the racing program's operating hours for reporting any problems or delays to the public.

d. Approval.

(1) All simulcasting, both interstate and intrastate, must be preapproved by the commission or commission representative. Each facility conducting simulcasting submits an annual written simulcast proposal to the commission with the application for license renewal.

(2) The commission representative, upon written request, may grant modifications to the annual simulcast proposal. The commission representative may approve or disapprove simulcast requests at the representative's discretion. Factors that may be considered include but are not limited to economic conditions of a facility, impact on other facilities, impact on the Iowa breeding industry, other gambling in the state, and any other considerations the commission representative deems appropriate.

(3) Once simulcast authority has been granted by the commission or commission representative, it is the affirmative responsibility of the facility granted simulcast authority to obtain all necessary permission from other jurisdictions and tracks to simulcast the pari-mutuel races. In addition, the burden of adhering to state and federal laws concerning simulcasting rests on the facility at all times.

8.4(2) *Simulcast host.*

a. Every host facility, if requested, may contract with an authorized receiver for the purpose of providing authorized users its simulcast. All contracts governing participation in interstate or intrastate pools must be submitted to the commission representative for prior approval. Contracts should be of such content and in such format as required by the commission representative.

b. A host facility is responsible for the content of the simulcast and should use all reasonable effort to present a simulcast that offers the viewers an exemplary depiction of each performance.

c. Unless otherwise permitted by the commission representative, every simulcast will contain in its video content a digital display of actual time of day, the name of the host facility from which the simulcast originates, the number of the contest being displayed, and any other relevant information available to patrons at the host facility.

d. The host facility must maintain such security controls, including encryption over its uplink and communications systems, as directed or approved by the commission or commission representative.

e. Financial reports are submitted daily or as otherwise directed by the commission representative. Reports must be of such content and in such format as required by the commission representative.

8.4(3) *Authorized receiver.*

a. An authorized receiver provides:

(1) Adequate transmitting and receiving equipment of acceptable broadcast quality that does not interfere with the closed circuit TV system of the host facility for providing any host facility patron information.

(2) Pari-mutuel terminals, pari-mutuel odds displays, modems and switching units enabling pari-mutuel data transmissions, and data communications between the host and guest facilities.

(3) A voice communication system between each guest facility and the host facility providing timely voice contact among the commission representative, placing judges, and mutuel departments.

b. The guest facility and all authorized receivers must conduct pari-mutuel wagering pursuant to the applicable commission rules.

c. Not less than 30 minutes prior to the commencement of transmission of the performance of pari-mutuel contests, the guest facility should initiate a test program of its transmitter, encryption and decoding, and data communication to ensure proper operation of the system.

d. The guest facility should, in conjunction with the host facility or facilities for which it operates pari-mutuel wagering, provide the commission representative with a certified report of its pari-mutuel operations as directed by the commission representative.

e. Every authorized receiver must file with the commission an annual report of its simulcast operations and an audited financial statement.

f. The mutuel manager will notify the commission representative when the transfer of pools, pool totals, or calculations are in question, or if partial or total cancellations occur, and will suggest alternatives for continued operation. Should loss of video signal occur, wagering may continue with approval from the commission representative.

491—8.5(99D) Interstate common-pool wagering.

8.5(1) *General.*

a. All contracts governing participation in interstate common pools should be submitted to the commission representative for prior approval. Financial reports are submitted daily or as otherwise directed by the commission representative. Contracts and reports should be of such content and in such format as required by the commission representative.

b. Individual wagering transactions are made at the point of sale in the state where placed. Pari-mutuel pools are combined for computing odds and calculating payoffs but will be held separate for auditing and all other purposes.

c. Any surcharges or withholdings in addition to the takeout may be applied only in the jurisdiction otherwise imposing such surcharges or withholdings.

d. In determining whether to approve an interstate common pool that does not include the host facility or that includes contests from more than one facility, the commission representative will consider and may approve use of a bet type that is not utilized at the host facility, application of a takeout rate not in effect at the host facility, or other factors that are presented to the commission representative.

e. The content and format of the visual display of racing and wagering information at facilities in other jurisdictions where wagering is permitted in the interstate common pool need not be identical to the similar information permitted or required to be displayed under these rules.

8.5(2) *Guest state participation in interstate common pools.*

a. With the prior approval of the commission representative, pari-mutuel wagering pools may be combined with corresponding wagering pools in the host state or with corresponding pools established by one or more other jurisdictions.

b. The commission representative may permit adjustment of the takeout from the pari-mutuel pool so that the takeout rate in this jurisdiction is identical to that of the host facility or identical to that of other jurisdictions participating in a merged pool.

c. When takeout rates in the merged pools are not identical, the net-price calculation is the method by which the differing takeout rates are applied.

d. Rules established in the state of the host facility designated for a pari-mutuel pool apply.

e. The commission representative will approve agreements made between the facility and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.

f. If, for any reason, it becomes impossible to successfully merge the bets placed into the interstate common pool, the facility will make payoffs in accordance with payoff prices that would have been in effect if prices for the pool of bets were calculated without regard to wagers placed elsewhere, except

that, with the permission of the commission representative, the facility may alternatively determine either to pay winning tickets at the payoff prices at the host facility or to declare such accepted bets void and make refunds in accordance with the applicable rules.

8.5(3) *Host state participation in merged pools.*

a. With the prior approval of the commission representative, a facility licensed to conduct pari-mutuel wagering may determine that one or more of its contests be utilized for pari-mutuel wagering at guest facilities in other jurisdictions and may also determine that pari-mutuel pools in guest jurisdictions be combined with corresponding wagering pools established by it as the host facility or comparable wagering pools established by two or more jurisdictions.

b. When takeout rates in the merged pool are identical, the net-price calculation is the method by which the differing takeout rates are applied.

c. Rules of racing established for races held in this state also apply to interstate common pools unless the commission representative specifically determines otherwise.

d. The commission representative must approve agreements made between the facility and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.

e. Any contract for interstate common pools entered into by the facility must contain a provision to the effect that if, for any reason, it becomes impossible to successfully merge the bets placed in another jurisdiction into the interstate common pool formed by the facility or if, for any reason, the commission representative or facility determines that attempting to effect transfer of pool data from the guest jurisdiction may endanger the facility's wagering pool, the facility will have no liability for any measure taken that may result in the guest's wagers not being accepted into the pool.

8.5(4) *Takeout rates in interstate common pools.*

a. With the prior approval of the commission representative, a facility wishing to participate in an interstate common pool may change its takeout rate so as to achieve a common takeout rate with all other participants in the interstate common pool.

b. A facility wishing to participate in an interstate common pool may request that the commission representative approve a methodology whereby host facility and guest facility jurisdictions with different takeout rates for corresponding pari-mutuel pools may effectively and equitably combine wagers from the different jurisdictions into an interstate common pool.

491—8.6(99D) Advance deposit wagering.

8.6(1) *Authorization to conduct advance deposit wagering.*

a. A licensee may request authorization from the commission to conduct advance deposit wagering pursuant to Iowa Code section 99D.11(6)*"c"* and this chapter and in the format outlined in 491—Chapter 1. The commission may require changes in a proposed plan of operations as a condition of granting a request. No subsequent changes in the system's operation may occur unless a written request is received and approved in writing by the administrator.

b. The commission may conduct investigations or inspections or request additional information from the licensee as the commission deems appropriate in determining whether to allow the licensee to conduct advance deposit wagering.

c. The licensee will establish and manage an advance deposit wagering center.

d. The commission may issue an ADWO license to an entity that enters into an agreement with the commission, the licensee, and the Iowa horsemen's benevolent and protective association. The terms of any ADWO's license include but are not limited to:

(1) Any source market fees and host fees to be paid on any races subject to advance deposit wagering.

(2) An annual ADWO license fee in an amount to be determined by the commission.

(3) Completion of all necessary background investigations.

(4) Acceptance of wagers on live races conducted at the horse racetrack in Polk County from all of its licensee account holders.

(5) A bond or irrevocable letter of credit on behalf of the ADWO to be determined by the commission.

(6) A detailed description and certification of systems and procedures used by the ADWO to validate the identity and age of licensee account holders and to validate the legality of wagers accepted.

(7) Secure retention of all records and recordings related to advance deposit wagering and accounts, including but not limited to records relating to licensee account holder identity and age, for a period of not less than three years or such longer period as specified by the commission, and in hard-copy or standard electronic format acceptable to the commission.

(8) Utilization and communication of pari-mutuel wagers to a pari-mutuel system meeting all requirements for pari-mutuel systems employed by licensed racing facilities in Iowa.

e. Commission access to and use of information concerning advance deposit wager transactions and licensee account holders is considered proprietary, and such information will not be disclosed publicly except as may be required pursuant to statute or court order or except as part of the official record of any proceeding before the commission. This requirement does not prevent the sharing of this information with other pari-mutuel regulatory authorities or law enforcement agencies for investigative purposes.

8.6(2) *Establishing an account.*

a. A person must have an established account to place advance deposit wagers. An account may be established in person at the licensee's facility or with the ADWO by mail or electronic means.

b. Advance deposit wagering account registration is subject to the same requirements as advance deposit sports wagering account registration under 491—paragraphs 13.5(2)*"a"* through *"g."*

c. The licensee and ADWO must review and deactivate accounts of newly enrolled participants of the statewide self-exclusion program and comply with all other self-exclusion requirements set forth by the commission and in Iowa Code sections 99D.7(23) and 99F.4(22).

d. The account is nontransferable.

e. The licensee or ADWO may close or refuse to open an account for what it deems good and sufficient reason and will order an account closed if it is determined that information used to open an account was false.

8.6(3) *Operation of an account.* The ADWO submits operating procedures with respect to licensee account holder accounts for commission approval. The submission includes internal controls and reasonable methods that provide for the following:

a. Written notification to the commission consistent with 491—paragraph 5.4(5)*"c."*

b. The segregation of incompatible functions so that no employee is in a position to perpetrate and conceal errors or irregularities in the normal course of the employee's duties.

c. User access controls for all sensitive and secure, physical and virtual, areas and systems within a wagering operation.

d. Problem gambling controls consistent with 491—subrule 5.4(12).

e. Setoff winnings of patrons who have a valid lien established under Iowa Code chapter 99D.

8.6(4) *Records.* Licensees must provide all information requested by the commission within a time as ordered or requested by the commission. It is the licensee's responsibility to ensure all books and records and the retention of all books and records comply with 491—subrule 5.4(14). All records pertaining to contests should be available to allow for player complaint resolution. All records pertaining to the accounts of people who registered or have account activity in Iowa should be available to allow for audits and investigations.

491—8.7(99D) Alternative simulcast operator.

8.7(1) *Authorization to conduct alternative simulcast.*

a. An entity may request authorization from the commission to conduct alternative simulcast wagering pursuant to Iowa Code section 99D.9D and this chapter in the format outlined in 491—Chapter 1. The commission may require changes to a proposed plan of operations as a condition of granting a request. No subsequent changes in the system's operation may occur unless a written request is received and approved in writing by the administrator.

b. The commission may conduct investigations or inspections or request additional information from the entity as the commission deems appropriate in determining whether to allow an entity to conduct an alternative simulcast operation.

c. The entity will establish and manage an alternative simulcast wagering center or subscribe to a service authorized by the commission.

d. The commission may issue an ASO license that complies with the requirements of Iowa Code section 99D.9D and the additional criteria as established by the commission. The terms of any ASO license include but are not limited to:

(1) Fees to be paid on any races subject to pari-mutuel wagering.

(2) An annual license fee in an amount to be determined by the commission.

(3) Completion of all necessary background investigations as determined by the commission.

(4) Acceptance of wagers on live races conducted at the horse racetrack in Polk County.

(5) A bond or irrevocable letter of credit on behalf of the alternative simulcast operator to be determined by the commission.

(6) Secure retention of all records related to alternative simulcast and off-track wagering for a period of not less than three years or such longer period as specified by the commission.

(7) Utilization and communication of pari-mutuel wagers to a pari-mutuel system meeting all requirements for pari-mutuel systems employed by licensed racing facilities in Iowa.

e. Commission access to and use of information concerning alternative simulcast and off-track wager transactions is considered proprietary, and such information will not be disclosed publicly except as may be required pursuant to statute or court order or except as part of the official record of any proceeding before the commission. This requirement does not prevent the sharing of this information with other pari-mutuel regulatory authorities or law enforcement agencies for investigative purposes.

8.7(2) *Operation of an ASO.* The ASO submits operating procedures and internal controls that provide for the following:

a. Written notification to the commission consistent with 491—paragraph 5.4(5)*"c."*

b. The segregation of incompatible functions so that no employee is in a position to perpetrate and conceal errors or irregularities in the normal course of the employee's duties.

c. User access controls for all sensitive and secure, physical and virtual, areas and systems within a wagering operation.

d. Problem gambling controls consistent with 491—subrule 5.4(12).

e. Setoff winnings of patrons who have a valid lien established under Iowa Code chapter 99D.

These rules are intended to implement Iowa Code chapter 99D.

ARC 9802C

RACING AND GAMING COMMISSION[491]

Notice of Intended Action

Proposing rulemaking related to thoroughbred and quarter horse racing and providing an opportunity for public comment

The Racing and Gaming Commission hereby proposes to rescind Chapter 10, "Thoroughbred and Quarter Horse Racing," Iowa Administrative Code, and to adopt a new Chapter 10 with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 99D.7, 99D.8A, 99D.9, 99D.9B, 99D.10, 99D.11, 99D.22, 99D.23, 99D.25, and 99D.25A and Executive Order 10.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 99D and Executive Order 10.

Purpose and Summary

In accordance with Executive Order 10, the Commission proposes to rescind Chapter 10 and adopt a new chapter in lieu thereof. Chapter 10 provides standards for thoroughbred and quarter horse racing, including parameters for the track and facilities; conduct guidelines for occupationally licensed racing personnel; and guidelines for other aspects of racing, such as the process for claiming horses in a claiming race. The proposed rulemaking consolidates or eliminates some rules according to Executive Order 10 and repromulgates others. Some subrules are proposed for reorganization into standalone rules. In particular, the proposed rulemaking splits Commission steward and Commission veterinarian information into a standalone rule and also splits jockey information into a standalone rule (jockeys were previously included in the same rule as trainers).

In addition, the proposed rulemaking includes some rules that were previously discussed with industry stakeholders but not yet completed through the rulemaking process, including amendments to allowable nonsteroidal anti-inflammatory drug levels and revamped jockey agent guidelines. Also, the proposed rulemaking includes some new substantive provisions, such as authorizing the stewards to postpone or cancel races with input from stakeholders and providing additional details about the process for claiming horses in claiming races.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025. A public hearing was held on the following date(s):

- November 18, 2025

One comment was received that sought additional clarity on the proposed rule addressing the stewards' authority to postpone or cancel races (proposed new subrule 10.4(1)*"f"*). After considering the comment, the Commission agrees that more detail in the rule would be beneficial. Thus, the proposed rulemaking in this Notice changes the relevant subrule from the version appearing as part of the Regulatory Analysis. The amended version of this subrule, set forth in this Notice, (1) better defines the personnel to be consulted, and (2) provides the stewards will make the final postponement or cancellation decision when (a) there is not unanimous agreement or (b) circumstances make it impracticable to convene all personnel. No other comments were received.

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 Commission for a waiver of the discretionary provisions, if any, pursuant to 491—Chapter 1.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on January 13, 2026. Comments should be directed to:

Barb Blake
Iowa Racing and Gaming Commission
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321
Email: barb.blake@iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

January 13, 2026 9 a.m.	Commission Office 6200 Park Avenue, Suite 100 Des Moines, Iowa
January 13, 2026 2 p.m.	Commission Office 6200 Park Avenue, Suite 100 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 Commission 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 491—Chapter 10 and adopt the following **new** chapter in lieu thereof:

CHAPTER 10
THOROUGHBRED AND QUARTER HORSE RACING

491—10.1(99D) Definitions. As used in this chapter, unless the context otherwise requires, the following definitions apply:

"Administrator" means the administrator of the commission appointed under Iowa Code section 99D.6(2) or the administrator's designee.

"Age" means the age of a horse calculated from the first day of January of the year of foaling.

"Allowance race" means an overnight race for which eligibility and weight to be carried are determined according to specified conditions that include age, sex, earnings, and number of wins.

"Also eligible" means:

1. A number of eligible horses, properly entered, that were not drawn for inclusion in a race but that become eligible according to preference or lot when an entry is scratched prior to the scratch time deadline; or

2. The next preferred nonqualifier for the finals or consolation from a set of elimination trials that will become eligible in the event a finalist is scratched by the stewards for a rule violation or that is otherwise eligible if written race conditions permit.

"Appeal" means a request for the commission or its designee to investigate, consider, and review any decisions or rulings of stewards.

"Arrears" means all moneys owed by a licensee, including subscriptions, jockey fees, forfeitures, and any default incident to these rules.

"Authorized agent" means a person licensed by the commission and appointed by a written instrument, signed and acknowledged before a notary public by the owner on whose behalf the agent will act.

"Bleeder" means the same as defined in Iowa Code section 99D.25A(1)*"a."*

"Chemist" means any official racing chemist or laboratory designated by the commission.

"Claiming race" means a race in which any horse starting may be claimed (purchased for a designated amount) in conformance with the rules. (More information can be found in the waived claiming rule in paragraph 10.8(15)*"k."*)

"Commission representative" means a gaming representative, steward, or any person designated by the commission or administrator.

"Conditions" means qualifications that determine a horse's eligibility to be entered in a race.

"Contest" means a competitive racing event on which pari-mutuel wagering is conducted.

"Coupled entry" means two or more contestants in a contest that are treated as a single betting interest for pari-mutuel wagering purposes. (See also "entry.")

"Day" means a 24-hour period ending at midnight.

"Dead heat" means when the noses of two or more horses reach the finish line of a race at the same time.

"Declaration" means the act of withdrawing an entered horse from a race prior to the closing of entries.

"Detention barn" means the barn designated for the collection from horses of test samples under the supervision of the commission veterinarian.

"Entry" means a horse made eligible to run in a race; or two or more horses, entered in the same race, that have common ties of ownership, lease, or training. (See also "coupled entry.")

"Facility" means an entity licensed by the commission to conduct pari-mutuel wagering or gaming operations in Iowa.

"Facility premises" means all real property utilized by the facility in the conduct of its race meeting, including the racetrack, grandstand, concession stands, offices, barns, stable area, employee housing facilities, parking lots, and any other areas under the jurisdiction of the commission.

"Field or mutuel field" means a group of two or more horses upon which a single bet may be placed. A mutuel field is required when the number of horses starting in a race exceeds the capacity of the track totalizator. The highest numbered horse within the totalizator capacity and all the higher-numbered horses following are then grouped together in the mutuel field.

"Foreign substances" means all substances except those that exist naturally in the untreated horse at normal physiological concentration.

"Forfeit" means money due from a licensee because of an error, fault, neglect of duty, breach of contract, or penalty imposed by the stewards or the commission.

"Handicap" means a race in which the weights to be carried by the horses are assigned by the racing secretary or handicapper for the purpose of equalizing the chances of winning for all horses entered.

"Horse" means any equine (including equine designated as a mare, filly, stallion, colt, ridgeling, or gelding) registered for racing; specifically, an entire male five years of age and older.

"Hypodermic injection" means any injection into or under the skin or mucosa, including intradermal injection, subcutaneous injection, submucosal injection, intramuscular injection, intravenous injection, intra-arterial injection, intra-articular injection, intrabursal injection, and intraocular or intraconjunctival injection.

"Inquiry" means an investigation by the stewards of potential interference in a contest prior to declaring the result of said contest official.

"Jockey" means a professional rider licensed to ride in races.

"Meet" or *"meeting"* means the specified period and dates each year during which a facility is authorized by the commission to conduct pari-mutuel wagering on horse racing.

"Nomination" means the naming of a horse to a certain race or series of races generally accompanied by payment of a prescribed fee.

"Nominator" means the person or entity in whose name a horse is nominated for a race or series of races.

"Objection" means:

1. A written complaint made to the stewards concerning a horse entered in a race and filed not later than one hour prior to the scheduled post time of the first race on the day in which the questioned horse is entered; or

2. A verbal claim of foul in a race lodged by the horse's jockey, trainer, owner, or the owner's authorized agent before the race is declared official.

"Official starter" means the official responsible for dispatching the horses for a race.

"Official time" means the elapsed time from the moment the first horse crosses the starting point until the first horse crosses the finish line.

"Overnight race," also known as a purse race, means a contest for which entries close at a time set by the racing secretary.

"Owner" means a person or entity that holds any title, right or interest, whole or partial, in a horse, including the lessee and lessor of a horse.

"Paddock" means an enclosure in which horses scheduled to compete in a contest are saddled prior to racing.

"Performance" means a schedule of 8 to 12 races per day unless otherwise authorized by the commission.

"Post position" means the preassigned position from which a horse will leave the starting gate.

"Post time" means the scheduled time for horses to arrive at the starting gate for a contest.

"Prize" means the combined total of any cash, premium, trophy, and object of value awarded to the owners of horses according to order of finish in a race.

"Purse" means the total cash amount for which a race is contested.

"Purse race" means a race for money or other prize to which the owners of horses entered do not contribute money toward its purse.

"Race" means a running contest between horses ridden by jockeys for a purse, prize, or other reward run at a facility in the presence of the stewards of the meeting. This includes purse races, overnight races and stakes races.

"Recognized meeting" means any meeting with regularly scheduled flat races for horses in a jurisdiction having reciprocal relations with this state and the commission for the mutual enforcement of rulings relating to horse racing.

"Scratch" means the act of withdrawing an entered horse from a contest after the closing of entries.

"Scratch time" means the deadline set by the facility for withdrawal of entries from a scheduled performance.

"Stakes race" means a contest in which nomination (if applicable), entry, and starting fees contribute to the purse. No overnight race is considered a stakes race. Special designations or classifications for stakes races such as "graded stakes" or "black type" will be determined by the appropriate breed registries or recognized authorities.

"Starter" means a horse that becomes an actual contestant in a race by virtue of the starting gate opening in front of it upon dispatch by the official starter.

"Steward" means a duly appointed racing official with powers and duties specified by rules.

"Subscription" means moneys paid for nomination, entry, eligibility, or starting of a horse in a stakes race.

"Test level" means the concentration of a foreign substance found in the test sample.

"Test sample" means any bodily substance, including but not limited to blood, urine, or hair, taken from a horse under the supervision of the commission veterinarian and as prescribed by the commission for the purpose of analysis.

"Totalizator" means the system used for recording, calculating, and disseminating information about ticket sales, wagers, odds, and payoff prices to patrons at a pari-mutuel wagering facility.

"Veterinarian" means a veterinarian holding a current unrestricted license issued by the state of Iowa veterinary regulatory authority and licensed by the commission.

"Winner" means the horse whose nose reaches the finish line first or is placed first through disqualification by the stewards.

"Year" means a calendar year.

491—10.2(99D) Facilities' responsibilities.

10.2(1) *Stalls.* A facility must ensure racing animals are stabled in individual box stalls; that the stables and immediate surrounding area are maintained in approved sanitary condition at all times; that satisfactory drainage is provided; and that manure and other refuse are kept in separate boxes or containers at locations distant from living quarters and are promptly and properly removed.

10.2(2) *Paddocks and equipment.* A facility must ensure that paddocks, starting gates, and other equipment subject to contact by different animals are kept in a clean condition and free of dangerous surfaces.

10.2(3) *Receiving barn and stalls.* A facility must provide a conveniently located receiving barn or stalls for the use of horses arriving during the meeting. The barn must have adequate stable room and facilities, hot and cold water, and stall bedding. A facility must employ attendants to operate and maintain the receiving barn or stalls in a clean and healthy condition.

10.2(4) *Fire safety and prevention.* The facility must develop and implement a program for fire safety and prevention on facility premises in accordance with applicable state fire codes and with Horseracing Integrity and Safety Authority rule 2163—Fire Safety as amended to [effective date of the rulemaking], approved by the Federal Trade Commission. The facility must instruct employees working on facility premises in procedures for fire prevention and evacuation. The facility must, in accordance with state fire codes, prohibit the following:

a. Smoking in horse stalls, in feed and tack rooms, and in the alleyways.

b. Sleeping in feed rooms or stalls.

c. Open fires and oil- or gasoline-burning lanterns or lamps in the stable area.

d. Leaving any electrical appliance unattended or in unsafe proximity to walls, beds, or furnishings.

e. Keeping flammable materials, including cleaning fluids or solvents, in the stable area.

f. Locking a stall that is occupied by a horse.

The facility must post a notice in the stable area that lists the prohibitions outlined in paragraphs 10.2(4)*"a"* through *"f"* above.

10.2(5) *Starting gate.*

a. During racing hours a facility must provide at least two operable padded starting gates that have been approved by the commission.

b. During designated training hours a facility must make at least one starting gate and qualified starting gate employee available for schooling.

c. If a race is started at a place other than in a chute, the facility must provide and maintain in good operating condition backup equipment for moving the starting gate. The backup equipment must be immediately available to replace the primary moving equipment in the event of failure.

10.2(6) *Distance markers.* A facility must provide and maintain starting point markers and distance poles in a size and position that can be clearly seen from the steward's stand. The starting point markers and distance poles will be marked as approved by the stewards.

10.2(7) *Detention enclosure.* Each facility must maintain a detention barn or enclosure for use by the commission.

a. The detention barn will be under the supervision of the commission veterinarian.

b. The detention barn will be used for securing samples of urine, saliva, blood, hair, or other bodily substances or tissues for chemical analysis from horses, or any other tests required by the commission.

c. The detention barn must include a wash rack, a commission veterinarian office, a walking ring, at least four stalls, a workroom for the sample collectors with hot and cold running water, refrigeration, and glass observation windows for viewing of the horses from the office and workroom.

d. An owner, trainer, or designated representative licensed by the commission must be with a horse in the detention barn at all times.

e. A security guard must be in attendance at each access to the detention barn as designated by the commission.

f. The building, location, arrangement, furnishings, and facilities are subject to commission approval.

10.2(8) *Ambulance.* A facility must maintain, on the premises during every day that its track is open for racing or exercising, an ambulance for humans and an ambulance for horses, equipped according to prevailing standards and staffed by medical doctors, paramedics, or other personnel trained to operate them. When an ambulance is used for transfer of a horse or patient to medical facilities, a replacement ambulance must be furnished by the facility to comply with this rule.

10.2(9) *Helmets and vests.* Any person on horseback on facility grounds must wear a protective helmet and safety vest that comply with the safety standards for helmets and vests set forth in the most current edition of the Horseracing Integrity and Safety Authority Rulebook, rule 2293—Equipment as amended to [effective date of the rulemaking], approved by the Federal Trade Commission.

10.2(10) *Racetrack surface and rails.* The surface and rails of a racetrack, including track cushion, subsurface, base, inside rails, and outside rails, must be designed, constructed, and maintained to provide for the safety of the jockeys and horses in accordance with the most current edition of the Horseracing Integrity and Safety Authority Rulebook, rule 2153—Racetrack Facilities, paragraphs (a), (b), and ©, as amended to [effective date of the rulemaking], approved by the Federal Trade Commission.

10.2(11) *Films, recordings, and photographs.* A facility must provide:

a. A video or digital recording system approved by the commission. Cameras must be located to provide clear panoramic and head-on views of each race. Separate monitors, which simultaneously display the images received from each camera and are capable of simultaneously displaying a synchronized view of the recordings of each race for review, must be provided in the stewards' stand. The location and construction of video towers must be approved by the commission.

b. One camera, designated by the commission, to record the prerace loading of all horses into the starting gate and to continue to record until the field is dispatched by the starter.

c. One camera, designated by the commission, to record the apparent winner of each race from the finish line until the horse has returned, the jockey has dismounted, and the equipment has been removed from the horse.

d. At the discretion of the stewards, video camera operators to record the activities of any horses or persons handling horses prior to, during, or following a race.

e. That races run on an oval track be recorded by at least three video cameras. Races run on a straight course must be recorded by at least two video cameras.

f. Upon request of the commission, without cost, a copy of a video recording or photo finish of a race.

g. That video recordings recorded prior to, during, and following each race be maintained by the facility for not less than six months after the end of the race meeting, or such other period as may be requested by the stewards or the commission.

h. A viewing room in which, on approval by the stewards, an owner, trainer, jockey, or other interested individual may view a video recording of a race.

i. Following any race in which there is an inquiry or objection, the replays of the incident in question that were utilized by the stewards in making their decision. The facility will display to the public these replays on designated monitors.

10.2(12) *Communications.*

a. Each facility must provide and maintain in good working order a communication system between:

(1) The stewards' stand;
(2) The racing office;
(3) The tote room;
(4) The jockeys' room;
(5) The paddock;
(6) The test barn;
(7) The starting gate;
(8) The weigh-in scale;
(9) The video camera locations;
(10) The clocker's stand;

(11) The commission veterinarian;

(12) The track announcer;

(13) The location of the ambulances (equine and human); and

(14) Other locations and persons designated by the commission.

b. A facility must provide and maintain a public address system capable of clearly transmitting announcements to the patrons and to the stable area.

491—10.3(99D) Facility policies. It is each occupational licensee's affirmative responsibility and continuing duty to follow and comply with facility policies published in literature distributed by a facility, listed in the condition book, or posted in a conspicuous location.

491—10.4(99D) Racing officials appointed or employed by the commission.

10.4(1) *Stewards.* There will be three stewards for each racing meet. Two stewards will be appointed or employed by the commission and one will be nominated by the facility under rule 491—10.5(99D), subject to commission approval. Facility nominees for the steward position, and biographical information describing the nominees' experience and qualifications, are due to the commission no later than 45 days before a race meeting begins.

a. Stewards' general authority.

(1) General. The board of stewards for each racing meet oversees the conduct of the racing meet in accordance with the laws of this state, the rules adopted by the commission, and the facility's policies and condition book. The stewards have authority to regulate and to resolve conflicts or disputes among all other racing officials, licensees, and those persons addressed by 491—paragraph 4.6(5)*"e"* that are reasonably related to the conduct of a race or races and to discipline violators of these rules in accordance with these rules.

(2) Period of authority. The stewards' authority commences 30 days prior to the beginning of each racing meet and terminates 30 days after the end of each racing meet or with the completion of their business pertaining to the meeting.

(3) Attendance. Three stewards will be present in the stand during the running of each race.

(4) Appointment of substitute. Should any steward be absent at race time, the state stewards will appoint a deputy for the absent steward. If any deputy steward is appointed, the stewards will immediately notify the administrator.

(5) Initiate action. The stewards will take notice of questionable conduct or law or rule violations with or without complaint, will initiate investigations promptly, and will render a decision on every objection and every complaint made to them.

(6) General enforcement provisions. Stewards enforce the laws of Iowa and the rules of the commission. The laws of Iowa and the rules of racing apply equally during periods of racing. They supersede the conditions of a race or meet and, in matters pertaining to racing, the orders of the stewards supersede the orders of the officers of a facility. The decision of the stewards as to the extent of a disqualification of any horse in any race is final.

b. Other powers and authority.

(1) The stewards have the power to interpret the rules and to decide all questions not specifically covered by them.

(2) All questions within their authority are determined by a majority of the stewards.

(3) The stewards have control over and access to all areas of facility premises.

(4) The stewards have the authority to determine all questions arising with reference to entries and racing. Persons entering horses to run at licensed facilities agree in so doing to accept the decision of the stewards on any questions relating to a race or racing. The stewards, in their sole discretion, are authorized to determine whether two or more individuals or entities are operating as a single financial interest or as separate financial interests. In making this determination, the stewards consider all relevant information, including but not limited to the following:

1. Whether the parties pay bills from and deposit receipts in the same accounts.

2. Whether the parties share resources such as employees, feed, supplies, veterinary and farrier services, exercise and pony riders, tack, and equipment.

3. Whether the parties switch horses or owner/trainer for no apparent reason, other than to avoid restrictions of being treated as a single interest.

4. Whether the parties engage in separate racing operations in other jurisdictions.

5. Whether the parties have claimed horses, or transferred claimed horses, for the other's benefit.

6. If owners, whether one owner is paying the expenses for horses not in the owner's name as owner.

7. If trainers, whether the relationship between the parties is more consistent with that of a trainer and assistant trainer.

(5) The stewards have the authority to discipline, for violation of the rules, any person subject to their jurisdiction and, in their discretion, to impose fines or suspensions or both for infractions.

(6) The stewards have the authority to order the exclusion or ejection from all premises and enclosures of the facility any person who is disqualified for corrupt practices on any race course in any country.

(7) The stewards have the authority to request proof that a horse is itself not disqualified in any respect or nominated by or, wholly or in part, the property of a disqualified person. If proof is not provided to the stewards' satisfaction, the stewards may declare the horse disqualified.

(8) The stewards have the authority at any time to order an examination of any horse entered for a race or that has run in a race.

(9) To maintain necessary safety and health conditions and to protect public confidence in horse racing as a sport, the stewards may authorize one or more persons on their behalf to enter into or upon the buildings, barns, motor vehicles, trailers, or other places within the premises of a facility; to examine the same; to inspect and examine the person, personal property, and effects of any person within such place; and to seize any illegal articles or any items as evidence found.

(10) The stewards will maintain a log of all infractions of the rules and of all rulings of the stewards upon matters coming before them during the race meet.

(11) The state stewards must give prior approval for any person other than the commissioners or commission representative to be allowed in the stewards' stand.

c. Emergency authority.

(1) Substitute officials. When, in an emergency, any official is unable to discharge the official's duties, the stewards may approve the appointment of a substitute and will report the substitution immediately to the administrator.

(2) Substitute jockeys. The stewards have the authority, in an emergency, to place a substitute jockey on any horse in the event the trainer does not do so. Before using that authority, the stewards will in good faith attempt to inform the trainer of the emergency and to afford the trainer the opportunity to appoint a substitute jockey. If the trainer cannot be contacted, or if the trainer is contacted but fails to appoint a substitute jockey and inform the stewards of the substitution by 30 minutes prior to post time, then the stewards may appoint under this rule.

(3) Substitute trainer. The stewards have the authority in an emergency to designate a substitute trainer for any horse.

(4) Excuse horse. In case of accident or injury to a horse, or any other emergency deemed by the stewards before the start of any race, the stewards may excuse the horse from starting.

(5) Exercise authority. No person may exercise a horse on the track between races unless upon the approval of the stewards.

(6) Nonstarter. At the discretion of the stewards, any horse(s) precluded from having a fair start may be declared a nonstarter, and any wagers involving said horse(s) may be ordered refunded.

d. Investigations and decisions.

(1) Investigations. The stewards may, upon direction of the administrator, conduct inquiries and recommend to the commission the issuance of subpoenas to compel the attendance of witnesses and the production of reports, books, papers, and documents for any inquiry. The commission stewards have

the power to administer oaths and examine witnesses. The stewards will maintain records of every such inquiry made by them.

(2) Form reversal. The stewards will take notice of any marked reversal of form by any horse and will conduct an inquiry of the horse's owner, trainer, or other persons connected with the horse including any person found to have contributed to the deliberate restraint or impediment of a horse in order to cause it not to win or finish as near as possible to first.

(3) Fouls.

1. Extent of disqualification. Upon any claim of foul submitted to them, the stewards will determine the extent of any disqualification and place any horse found to be disqualified behind others in the race with which it interfered, or may place the offending horse last in the race. The stewards at their discretion may determine if there was sufficient interference or intimidation to affect the outcome of the race and take the appropriate actions thereafter.

2. Jockey guilty of foul. The stewards may discipline any jockey whose horse has been disqualified as a result of a foul committed during the running of a race.

(4) Protests and complaints. The stewards will investigate promptly and render a decision in every protest and complaint made to them. They will keep a record of all protests and complaints and any rulings made by the stewards and will provide regular reports as requested by the administrator.

1. Involving fraud. Protests involving fraud may be made by any person at any time. The protest is made to the stewards.

2. Not involving fraud. Protests, except those involving fraud, may be filed only by the owner of a horse, authorized agent, trainer, or the jockey of the horse in the race over which the protest is made. The protest must be made to the clerk of scales, the stewards, or a person designated by the stewards before the race is declared official. If the placement of the starting gate is in error, no protest may be made, unless entered prior to the start of the race.

3. Protest to clerk of scales. A jockey who intends to enter a protest following the running of any race, and before the race is declared official, must notify the clerk of scales, or a person designated by the stewards, of this intention immediately upon the arrival of the jockey at the scales.

4. Prize money of protested horse. During the time of determination of a protest, any money or prize won by a horse protested or otherwise affected by the outcome of the race will be paid to and held by the horsemen's bookkeeper until the protest is decided.

5. Protest in writing. A protest, other than one arising out of the actual running of a race, must be in writing, signed by the complainant, and filed with the stewards not later than one hour before post time of the race out of which the protest arises.

6. Frivolous protests. No person may make a frivolous protest, nor may any person withdraw a protest without the permission of the stewards.

e. Cancel wagering. The stewards have the authority to cancel wagering on an individual betting interest or on an entire race, and also have the authority to cancel a pari-mutuel pool for a race or races if such action is necessary to protect the integrity of pari-mutuel wagering.

f. Postpone or cancel races. The stewards have the authority to postpone or cancel races upon the advice of the commission veterinarians and after receiving input from the facility, the association or associations representing horse owners, and a jockey representative for one or more of the following reasons:

(1) Inclement weather, including but not limited to lightning or extreme heat or humidity;

(2) Air quality;

(3) Track conditions;

(4) Any other circumstance or condition that may endanger the safety and welfare of horses, racing participants, or both;

(5) Any other circumstance or condition that may call into question the integrity of racing.

10.4(2) *Commission veterinarians.*

a. The commission veterinarians employed or appointed by the commission advise the commission and the stewards on all veterinary and animal welfare matters.

b. The commission veterinarians have supervision and control of the detention barn for the collection of test samples for the testing of horses for prohibited substances as provided in Iowa Code sections 99D.23(2) and 99D.25(9). The commission may employ or appoint persons to assist the commission veterinarians in maintaining the detention barn area and collecting test samples.

c. The commission veterinarians cannot buy or sell any horse under their supervision, wager on a race under their supervision, or be licensed to participate in racing in any other capacity.

d. The stewards or commission veterinarians may request any horse entered in a race to undergo an examination on the day of the race to determine the general fitness of the horse for racing. During the examination, the commission veterinarians may request all bandages be removed by the groom and the horse be exercised outside the stall to determine the condition of the horse's legs and feet. The examining veterinarian will report any unsoundness in a horse to the stewards.

e. A commission veterinarian will inspect all of the horses in a race at the starting gate and, after the finish of a race, will observe the horses upon their leaving the track.

f. The commission veterinarian will place any horse determined to be sick or too unsafe, unsound, or unfit to race on a veterinarian's list that will be posted in a conspicuous place available to all owners, trainers, and officials.

g. A horse placed on the veterinarian's list in Iowa, bleeders exempt, may be allowed to enter only after it has been approved by the commission veterinarian. Any horse placed on the veterinarian's list will be removed from any future race in which the horse has been entered. Requests for the removal of any horse from the veterinarian's list will be accepted only after at least three calendar days have elapsed from the placing of the horse on the veterinarian's list. Removal from the list is at the discretion of the commission veterinarian, who may require satisfactory workouts or examinations to adequately demonstrate that the problem that caused the horse to be placed on the list has been rectified. Horses that are entered to race and then placed on the veterinarian's list for any reason will not be allowed to enter a race for at least three calendar days beginning the day after the horse was scheduled to race.

h. Every confirmed bleeder, regardless of age, will be placed on the bleeder list and be ineligible to race for the following time periods:

(1) First incident – 14 days.
(2) Second incident within 365-day period – 30 days.
(3) Third incident within 365-day period – 180 days.
(4) Fourth incident within 365-day period – barred for racing lifetime.

When counting the number of days a horse is ineligible to run, the day the horse bled externally is the first day of the recovery period. The voluntary administration of furosemide without an external bleeding incident will not subject the horse to the initial period of ineligibility specified in subparagraph 10.4(2)*"h"*(1). A horse may be removed from the bleeder list only upon the direction of the official veterinarian, who must certify in writing to the stewards the recommendation for removal. A horse that has been placed on a bleeder list in another jurisdiction pursuant to these rules will be placed on a bleeder list in this jurisdiction.

i. The commission veterinarians supervise and ensure that the administration of furosemide and phenylbutazone complies with Iowa Code section 99D.25A.

j. The commission veterinarian or commission representative takes receipt of veterinary reports required by Iowa Code section 99D.25(10) and these rules.

491—10.5(99D) Facility racing officials.

10.5(1) *General description.* A facility conducting a race meeting appoints at least the following officials:

a. One of the members of the three-member board of stewards;
b. Racing secretary;
c. Assistant racing secretary;
d. Paddock judge;
e. Horse identifier;
f. Starter;

g. Clocker/timer;
h. Three placing judges;
i. Jockey room custodian;
j. Mutuel manager;
k. Clerk of scales;
l. Minimum of two outriders;
m. Horsemen's bookkeeper; and
n. Any other person designated by the commission.

10.5(2) *Officials' prohibited activities.* No racing official or racing official's assistant(s) listed in subrule 10.5(1) while serving in that capacity during any meeting may engage in any of the following:

a. Conduct prohibited by Iowa Code section 99D.5(5)*"a"*;
b. Participation in the sale, purchase, or ownership of any horse racing at the meeting;
c. Involvement in any way in the purchase or sale of any contract on any jockey racing at the meeting;
d. Selling or soliciting horse insurance on any horse racing at the meeting, or any other business sales or solicitation not a part of the official's duties;
e. Accepting or receiving money or anything of value for the official's assistance in connection with the official's duties;
f. Consuming or being under the influence of alcohol or any prohibited substance while performing official duties.

10.5(3) *Single official appointment.* No official appointed to any meeting, except placing judges, may hold more than one official position listed in subrule 10.5(1) unless, in the determination of the stewards or commission, holding more than one appointment would not subject the official to a conflict of interest or duties in the two appointments.

10.5(4) *Racing secretary.*

a. General authority. The racing secretary is responsible for setting the conditions for each race of the meeting, regulating the nomination of entries, determining the amounts of purses and to whom they are due, and recording race results. The racing secretary can permit no person other than licensed racing officials to enter the racing secretary's office or work areas until such time as all entries are closed; drawn; and reviewed for correctness, eligibility, weight allowances, and medications. Exceptions to this rule may only be granted with the stewards' approval.

b. Conditions. The racing secretary establishes the conditions and eligibility for entering the races of the meeting and causes them to be published to owners, trainers, and the commission. Corrections to the conditions must be made before entries are taken.

c. Posting of entries. Upon the closing of entries each day, the racing secretary posts a list of entries in a conspicuous location in the office of the racing secretary and furnishes that list to local media.

d. Stakes and entrance money records. The racing secretary is the caretaker of the permanent records of all stakes, entrance moneys, and arrears paid or due in a race meeting and keeps permanent records of the results of each race of the meeting.

e. Record of racing. The racing secretary will, no later than the day following each race, attach or endorse on the registration certificate of each horse winning in any race the fact of that winning performance and the distance, date of the race, and type or conditions of the race.

f. Daily program. The racing secretary publishes the official daily program, ensuring the accuracy therein of the following information:

(1) The sequence of races to be run and post time for the first race;
(2) The purse, conditions and distance for each race, and current track record for such distance;
(3) The name of licensed owners of each horse, indicated as leased, if applicable, and description of racing colors to be carried;
(4) The name of the trainer and the name of the jockey named for each horse together with the weight to be carried;

(5) The post position and saddle cloth number or designation for each horse if there is a variance with the saddle cloth designation;

(6) The identification of each horse by name, color, sex, age, sire and dam;

(7) A notice that all jockeys will carry approximately three pounds more than the published weight to account for safety equipment (vest and helmet) that is not included in required weighing-out procedures; and

(8) Such other information as may be requested by the association or the commission.

g. Handicapping. The racing secretary, or a handicapper assigned by the racing secretary, assigns the weight to be carried by each horse in a handicap when weights are not stated in the condition of the race:

(1) Scale of weights for age. The scale of weights for age hereinafter listed are carried when conditions of races do not otherwise specify:

Distance	Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Two Years	X	X	X	X	X	X	X	105	108	111	114	114
HALF	Three Years	117	117	119	119	121	123	125	126	127	128	129	129
MILE	Four Years	130	130	130	130	130	130	130	130	130	130	130	130
	Five Years and Up	130	130	130	130	130	130	130	130	130	130	130	130
	Two Years	X	X	X	X	X	X	X	102	105	108	111	111
SIX	Three Years	114	114	117	117	119	121	123	125	126	127	128	128
FURLONGS	Four Years	129	129	130	130	130	130	130	130	130	130	130	130
	Five Years and Up	130	130	130	130	130	130	130	130	130	130	130	130
	Two Years	X	X	X	X	X	X	X	X	96	99	102	102
ONE	Three Years	107	107	111	111	113	115	117	119	121	122	123	123
MILE	Four Years	127	127	128	128	127	126	126	126	126	126	126	126
	Five Years and Up	128	128	128	128	127	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
MILE AND	Three Years	101	101	107	107	111	113	116	118	120	121	122	122
A QUARTER	Four Years	125	125	127	127	127	126	126	126	126	126	126	126
	Five Years and Up	127	127	127	127	127	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
MILE AND	Three Years	98	98	104	104	108	111	114	117	119	121	122	122
A HALF	Four Years	124	124	126	126	126	126	126	126	126	126	126	126
	Five Years and Up	126	126	126	126	126	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
TWO MILES	Three Years	96	96	102	102	106	109	112	114	117	119	120	120
	Four Years	124	124	126	126	126	126	126	125	125	124	124	124
	Five Years and Up	126	126	126	126	126	126	126	125	125	124	124	124

(2) Weights listed.

1. In races of intermediate lengths, the weights for the shorter distance are to be carried.
2. In a race exclusively for two-year-olds, the weight is 122 pounds.
3. In a race exclusively for three-year-olds or four-year-olds, the weight is 126 pounds.

(3) Minimum weight.

1. Thoroughbreds. In all overnight races for two-year-olds, three-year-olds, or four-year-olds and older, the minimum weight is 112 pounds, subject to sex and apprentice allowance. This rule does not apply to handicaps or to races written for three-year-olds and older.

2. Quarter horse and mixed races. In all overnight races for two-year-olds, the weight is 120 pounds; for three-year-olds, the weight is 122 pounds; and for four-year-olds and older, the weight is 124 pounds.

3. Quarter horse and mixed races. In qualifying for a speed index, standard weight is 120 pounds. Should any horse carry less than this amount in a race, one-tenth of a second will be added to the official time for each four pounds or fraction thereof less than 120 pounds.

(4) Sex allowances. In thoroughbred racing, sex allowances are obligatory. Sex allowances will be applied in all thoroughbred races unless the conditions of the race expressly state to the contrary. If the conditions of the race are silent as to sex allowances, a sex allowance will be applied. Sex allowances cannot be declined. Two-year-old fillies are allowed three pounds; mares three years old and older are allowed five pounds before September 1 and three pounds thereafter. Sex allowances are not applicable for quarter horse or mixed races.

(5) Iowa-foaled horse allowance. Iowa-foaled horses that are properly registered and whose papers are stamped, physically or digitally, by the Iowa department of agriculture and land stewardship are allowed an additional three pounds beyond the stated conditions of the race if the race is not limited to Iowa-foaled horses. This allowance does not apply to stakes races.

h. Penalties not cumulative. Penalties and weight allowances are not cumulative unless so declared in the conditions of a race by the racing secretary.

i. Winnings.

(1) All inclusive. For the purpose of the setting of conditions by the racing secretary, winnings are considered to include all moneys and prizes won up to the time of the start of a race, including those races outside the United States. Foreign winnings are determined on the basis of the normal rate of exchange prevailing on the day of the win. The amount of purse money earned is credited in United States currency, and there is no appeal for any loss on the exchange rate at the time of transfer from United States currency to that of another country.

(2) Winnings considered from January 1. Winnings during the year are reckoned by the racing secretary from the preceding January 1.

(3) Winner of a certain sum. "Winner of a certain sum" means the winner of a single race of that sum, unless otherwise expressed in the condition book by the racing secretary. In determining the net value to the winner of any race, the sums contributed by its owner or nominator will be deducted from the amount won. In all stakes races, the winnings will be computed on the value of the gross earnings.

j. Cancellation of a race. The racing secretary has the authority to withdraw, cancel, or change any race that has not been closed. In the event the race is canceled, any and all fees paid in connection with the race will be refunded.

k. Coggins test. The racing secretary will ensure that all horses have a current negative Coggins test. The racing secretary will report all expired certificates to the stewards.

l. Registrations and supporting documents. The racing secretary is responsible for receiving, inspecting, and safeguarding all registrations and supporting documents submitted by the trainer while the horses are located on facility premises. Upon notification from a trainer of an alteration of the sex of a horse, the racing secretary will note such alteration on the certificate of registration. Disclosure is made for the benefit of the public and all documents pertaining to the ownership or lease of a horse filed with the racing secretary are available for public inspection.

10.5(5) *Paddock judge.*

a. General authority. The paddock judge:

(1) Supervises the assembly of horses in the paddock no later than 15 minutes before the scheduled post time for each race;

(2) Maintains a written record of all equipment, inspects all equipment of each horse saddled, and reports any change thereof to the stewards;

(3) Prohibits any change of equipment without the approval of the stewards;

(4) Ensures that the saddling of all horses is orderly, open to public view, and free from public interference and that horses are mounted at the same time and leave the paddock for the post in proper sequence;

(5) Supervises paddock schooling of all horses approved for such by the stewards;

(6) Reports to the stewards any observed cruelty to a horse; and

(7) Ensures that only properly authorized persons are permitted in the paddock.

b. Paddock judge's list.

(1) The paddock judge maintains a list of horses that cannot be entered in a race because of poor or inconsistent behavior in the paddock that endangers the health or safety of other participants in racing.

(2) At the end of each day, the paddock judge provides a copy of the list to the stewards.

(3) To be removed from the paddock judge's list, a horse must be schooled in the paddock and demonstrate to the satisfaction of the paddock judge and the stewards that the horse is capable of performing safely in the paddock.

10.5(6) *Horse identifier.* The horse identifier:

a. When required, ensures the safekeeping of registration certificates and racing permits for horses stabled or racing on facility premises;

b. Inspects documents of ownership, eligibility, registration, or breeding necessary to ensure the proper identification of each horse scheduled to compete at a race meeting;

c. Examines every starter in the paddock for sex, color, markings, microchip, lip tattoo, or digital tattoo for comparison with its registration certificate to verify the horse's identity;

d. Supervises the tattooing, digital tattooing, microchipping or branding for identification of any horse located on facility premises; and

e. Reports to the stewards any horse not properly identified or whose registration certificate is not in conformity with these rules.

10.5(7) *Starter.*

a. General authority. The starter:

(1) Has complete jurisdiction over the starting gate, the starting of horses, and the authority to give orders not in conflict with the rules as may be required to ensure all participants an equal opportunity to a fair and safe start;

(2) Appoints and supervises assistant starters who have demonstrated they are adequately trained to safely handle horses in the starting gate. In emergency situations, the starter may appoint qualified individuals to act as substitute assistant starters;

(3) Assigns the starting gate stall positions to assistant starters and notifies the assistant starters of their respective stall positions on race day before post time for each race;

(4) Assesses the ability of each person applying for a jockey's license in breaking from the starting gate and working a horse in the company of other horses, and makes said assessment known to the stewards; and

(5) Loads horses into the gate in any order deemed necessary to ensure a safe and fair start.

b. Assistant starters. With respect to an official race, the assistant starters cannot:

(1) Handle or take charge of any horse in the starting gate without the expressed permission of the starter;

(2) Impede the start of a race;

(3) Use excessive force, a whip or other device, with the exception of steward-approved tongs, to assist in loading a horse into the starting gate;

(4) Slap, boot, or otherwise dispatch a horse from the starting gate;

(5) Strike or use abusive language to a jockey; or

(6) Accept or solicit any gratuity or payment other than their regular salary, directly or indirectly, for services in starting a race.

c. Starter's list. No horse may start in a race unless approval is given by the starter. The starter maintains a starter's list of all horses that are ineligible to be entered in any race because of poor or inconsistent behavior or performance in the starting gate. Any horse on the starter's list will be refused entry until the horse has demonstrated to the starter that it has been satisfactorily schooled in the gate and can be removed from the starter's list. Schooling will be under the direct supervision of the starter.

10.5(8) *Timer/clocker.*

a. General authority—timer.

(1) The timer must accurately record the official time.

(2) At the end of a race, the timer posts the official running time on the infield totalizator board on instruction by the stewards.

(3) At a facility equipped with an appropriate infield totalizator board, the timer will post the quarter times (splits) for thoroughbred races in fractions as a race is being run. For quarter horse races, the timer will post the official times in hundredths of a second.

(4) For backup purposes, the timer must also use a stopwatch to time all races. In time trials, the timer should ensure that at least two stopwatches are used by the stewards or their representatives.

(5) The timer maintains, and makes available for inspection by the stewards or the commission on request, a written record of fractional and finish times of each race.

b. General authority—clocker.

(1) The clocker will be present during training hours at each track on facility premises that is open for training to identify each horse working out and to accurately record the distances and times of each horse's workout.

(2) Each day, the clocker prepares a list of workouts that includes the name of each horse that worked along with the distance and time of each horse's workout.

(3) At the conclusion of training hours, the clocker delivers a copy of the list of workouts to the stewards and the racing secretary.

10.5(9) *Placing judges.*

a. General authority. The placing judges determine the order of finish in a race as the horses pass the finish line and, with the approval of the stewards, may display the results on the totalizator board.

b. Photo finish.

(1) In the event the placing judges or the stewards request a photo of the finish, the photo finish sign will be posted on the totalizator board.

(2) Following their review of the photo finish, the placing judges, with the approval of the stewards, determine the exact order of finish for all horses participating in the race and will immediately post the numbers of the first four finishers on the totalizator board.

(3) In the event a photo was requested, the placing judges will cause a photograph of said finish to be produced. The finish photograph, when needed, will be used by the placing judges as an aid in determining the correct order of finish.

(4) Upon determination of the correct order of finish of a race in which the placing judges have utilized a photograph to determine the first four finishers, the placing judges will cause said photograph to be displayed publicly in the grandstand and clubhouse areas of the facility.

c. Dead heats.

(1) If the placing judges determine that two or more horses finished the race simultaneously and cannot be separated as to their order of finish, a dead heat will, with the approval of the stewards, be declared.

(2) If one or more of the first four finishers of a race are involved in a dead heat, the placing judges will post the dead heat sign on the totalizator board and cause the numbers of the horse or horses involved to blink on the totalizator board.

10.5(10) *Jockey room custodian.* The jockey room custodian:

a. Supervises the conduct of the jockeys and their attendants while they are in the jockey room;

b. Keeps the jockey room clean and safe for all jockeys;

c. Ensures all jockeys are in the correct colors and wearing the correct arm number before leaving the jockey room to prepare for mounting their horses;

d. Keeps a daily film list as dictated by the stewards and has it displayed in plain view for all jockeys;

e. Keeps a daily program displayed in plain view for the jockeys;

f. Keeps unauthorized persons out of the jockey room;

g. Reports to the stewards any unusual occurrences in the jockey room or infraction of the rules with respect to helmets and vests;

h. Assists the clerk of scales as required;

i. Supervises the care and storage of racing colors; and

j. Assigns to each jockey a locker for the use of storing the jockey's clothing, equipment, and personal effects.

10.5(11) *Mutuel manager.* The mutuel manager is responsible for the operation of the mutuel department. The mutuel manager ensures that any delays in the running of official races caused by totalizator malfunctions are reported to the stewards. The mutuel manager will submit a written report on any delay when requested by the state steward.

10.5(12) *Clerk of scales.* The clerk of scales will:

a. Verify the presence of all jockeys in the jockey room at the appointed time;

b. Verify that each jockey has a current jockey's license issued by the commission;

c. Verify the correct weight of each jockey at the time of weighing out and weighing in and report any discrepancies to the stewards immediately;

d. Oversee the security of the jockey room including the conduct of the jockeys and their attendants;

e. Record all required data on the scale sheet and submit that data to the horsemen's bookkeeper at the end of each race day;

f. Maintain the record of applicable winning races on all apprentice certificates at the meeting;

g. Release apprentice jockey certificates, upon the jockey's departure or upon the conclusion of the race meet;

h. Assume the duties of the jockey room custodian in the absence of such employee; and

i. Promptly report to the stewards any infraction of the rules with respect to riding equipment; safety equipment, including but not limited to helmets and vests; riding crops; or conduct.

10.5(13) *Outrider.*

a. The facility must appoint a minimum of two outriders on the main track for each race of a performance and during workouts. The facility must appoint one outrider on the training track during all workouts. The outriders must be neat in appearance, wear approved helmets with the chin straps securely fastened, and wear approved safety vests while on the main track or training track.

b. The outriders:

(1) Accompany the field of horses from the paddock to the post;

(2) Ensure the post parade is conducted in an orderly manner, with all jockeys and pony riders conducting themselves in a manner in conformity with the best interests of racing as determined by the stewards;

(3) Assist jockeys with unruly horses;

(4) Render assistance when requested by a jockey;

(5) Are present during morning workouts to assist exercise riders as required by regulations;

(6) Promptly report to the stewards any unusual conduct that occurs while performing the duties of an outrider;

(7) Ensure individuals using the track(s) are appropriately licensed; and

(8) Promptly report jockey objections to the stewards after the finish of each race.

10.5(14) *Horsemen's bookkeeper.*

a. General authority. The horsemen's bookkeeper maintains the records and accounts and performs the duties described herein and maintains such other records and accounts and performs such other duties as the facility and commission may prescribe.

b. Records.

(1) The records will include the name, mailing address, social security number or federal tax identification number, and the state or country of residence of each horse owner, trainer, or jockey participating at the race meeting who has funds due or on deposit in the horsemen's account.

(2) The records will include a file of all required statements of partnerships, syndicates, corporations, assignments of interest, lease agreements, and registrations of authorized agents.

(3) All records of the horsemen's bookkeeper must be kept separate and apart from the records of the facility.

(4) All records of the horsemen's bookkeeper including records of accounts and moneys and funds kept on deposit are subject to inspection by the commission at any time.

c. Moneys and funds on account.

(1) All moneys and funds on account with the horsemen's bookkeeper must be maintained:

1. Separate and apart from moneys and funds of the facility;
2. In a trust account designated as "horsemen's trust account"; and
3. In an account insured by the Federal Deposit Insurance Corporation.

(2) The horsemen's bookkeeper must be bonded.

d. Payment of purses.

(1) The horsemen's bookkeeper receives, maintains, and disburses the purses of each race and all stakes, entrance money, jockey fees, purchase money in claiming races, all applicable taxes, and other moneys that properly come into the horsemen's bookkeeper's possession in accordance with the provisions of commission rules.

(2) The horsemen's bookkeeper may accept moneys due, belonging to other organizations or recognized meetings, provided prompt return is made to the organization to which the money is due.

(3) The horsemen's bookkeeper will disburse the purse of each race and all stakes, entrance money, and jockey fees, upon request, within two race days of the conclusion of the race day for all horses that were not selected for postrace drug testing.

(4) For horses that were selected for postrace drug testing, the horsemen's bookkeeper will disburse the purse of such horses for each race and all stakes, entrance money, and jockey fees, upon request, within two race days of receipt of notification that all tests with respect to such horses have cleared the drug testing laboratory (commission chemist) as reported by the stewards. Minimum jockey mount fees may be disbursed prior to notification that the tests have cleared the testing laboratory.

(5) Absent a prior request, the horsemen's bookkeeper will disburse moneys to the persons entitled to receive same within 15 days after the last race day of the race meeting, including purses for official races, provided that all tests with respect to such horses that have been selected for postrace drug testing have cleared the drug testing laboratory as reported by the stewards, and provided further that no protest or appeal has been filed with the stewards or the commission.

(6) If a protest or appeal has been filed with the stewards or the commission, the horsemen's bookkeeper will disburse the purse of such horses having been selected for postrace drug testing within two race days of receipt of dismissal or a final nonappealable order disposing of such protest or appeal.

e. No portion of purse money other than jockey fees may be deducted by the facility for itself or for another, unless so requested in writing by the person to whom purse moneys are payable or the person's duly authorized representative. The horsemen's bookkeeper will mail to each owner a duplicate of each record of all deposits, withdrawals, or transfers of funds affecting the owner's racing account at the close of each race meeting.

f. Purse money presumption. The fact that purse money has been distributed prior to the issuance of a laboratory report is not a finding that no chemical substance has been administered, in violation of these rules, to the horse earning the purse money.

10.5(15) *Patrol judges.*

a. General authority. A facility may employ patrol judges who observe the running of the race and report information concerning the running of the race to the stewards.

b. Duty stations. Each patrol judge will have a duty station assigned by the stewards.

491—10.6(99D) Trainers and assistant trainers.

10.6(1) *Trainer responsibility.*

a. The trainer is responsible for:

(1) The condition of horses entered in an official workout or race and, in the absence of substantial evidence to the contrary, for the presence of any prohibited drug, medication or other substance, including permitted medication in excess of the maximum allowable level, in such horses, regardless of the acts of third parties. A positive test for a prohibited drug, medication, or substance, including permitted medication in excess of the maximum allowable level, as reported by a commission-approved laboratory, is prima facie evidence of a violation of this rule or Iowa Code chapter 99D.

(2) Preventing the administration of any drug, medication, or other prohibited substance that may cause a violation of these rules. An "in-today" sign must be placed by 8 a.m. on race day next to the

stall of a horse that is scheduled to race on that day. For horses shipping in on race day, the sign must be placed upon the horse's arrival.

(3) Any violation of rules regarding a claimed horse's participation in the race in which the trainer's horse is claimed.

(4) The condition and contents of stalls, tack rooms, feed rooms, sleeping rooms, and other areas that have been assigned to the trainer by the facility and maintaining the assigned stable area in a clean, neat, and sanitary condition at all times.

(5) Ensuring that fire prevention rules are strictly observed in the assigned stable area.

(6) Being present to witness the administration of furosemide during the administration time and sign as the witness on the affidavit form. A licensed designee of the trainer may witness the administration of the furosemide and sign as the witness on the affidavit form; however, this designee cannot be another practicing veterinarian or veterinary assistant. If the trainer or designee is not present or does not allow for the administration of furosemide to a horse to be run on furosemide, said horse will be placed on the steward's list for a minimum of five days starting the day after the violation.

(7) The proper identity, custody, care, health, condition, and safety of horses in the trainer's charge.

(8) Disclosure to the racing secretary of the true and entire ownership of each horse in the trainer's care, custody, or control. Any change in ownership must be reported immediately to, and approved by, the stewards and recorded by the racing secretary. The disclosure, together with all written agreements and affidavits setting out oral agreements pertaining to the ownership for or rights in and to a horse, must be attached to the registration certificate for the horse and filed with the racing secretary.

(9) Training all horses owned wholly or in part by the trainer that are participating at the race meeting.

(10) Registering with the racing secretary each horse in the trainer's charge within 24 hours of the horse's arrival on facility premises.

(11) Ensuring that, at the time of arrival at the facility, each horse in the trainer's care is accompanied by a valid health certificate that is filed with the racing secretary.

(12) Having each horse in the trainer's care that is racing or stabled on facility premises tested for equine infectious anemia (EIA) in accordance with state law and for filing evidence of such negative test results with the racing secretary. The test must have been conducted within the previous 12 months and must be repeated upon expiration. The certificate must be attached to the foal certificate or otherwise accessible by the commission or racing association.

(13) Using the services of those veterinarians licensed by the commission to attend horses that are on facility premises.

(14) Properly recording the sex of the horses in the trainer's care with the horse identifier and the racing secretary and immediately reporting the alteration of the sex of a horse in the trainer's care to the horse identifier and the racing secretary.

(15) Promptly reporting to the racing secretary and the commission veterinarian any horse on which a posterior digital neurectomy (heel nerving) has been performed and ensuring that such fact is designated on its certificate of registration. More information can be found in Iowa Code section 99D.25(1) through 99D.25(3).

(16) Promptly reporting to the stewards and the commission veterinarian the serious illness of any horse in the trainer's charge.

(17) Promptly reporting the death of any horse in the trainer's care on facility premises to the stewards, owner, and the commission veterinarian and complying with Iowa Code section 99D.25(5) governing postmortem examination.

(18) Maintaining a knowledge of the medication record and status of all horses in the trainer's care.

(19) Immediately reporting to the stewards and the commission veterinarian if the trainer knows, or has cause to believe, that a horse in the trainer's custody, care, or control has received any prohibited drugs or medication.

(20) Representing an owner in making entries and scratches and in all other matters pertaining to racing.

(21) Eligibility of horses entered and weight or other allowance claimed.

(22) Ensuring the fitness of a horse to perform creditably at the distance entered.

(23) Ensuring that the trainer's horses are properly shod, bandaged, and equipped.

(24) Presenting the trainer's horse in the paddock at least 20 minutes before post time or at a time otherwise appointed before the race in which the horse is entered. Any horse failing to report to the paddock will be placed on the steward's list for a minimum of five days starting the day after the violation.

(25) Personally attending to the trainer's horses in the paddock and supervising the saddling thereof, unless excused by the stewards.

(26) Instructing the jockey to give the jockey's best effort during a race and instructing the jockey that each horse must be ridden to win.

(27) Witnessing the collection of bodily substances, including but not limited to urine, blood, or hair sample, from the horse in the trainer's charge or delegating a licensed employee or the owner of the horse to do so.

(28) Notifying horse owners upon the revocation or suspension of their trainer's license. A trainer whose license has been suspended for more than 30 days, whose license has expired or been revoked, or whose license application has been denied must inform the horse owners that, until the license is restored, the trainer can no longer be involved with the training, care, custody or control of their horses, nor receive any compensation from the owners for the training, care, custody or control of their horses. Upon application by the horse owner, the stewards may approve the transfer of such horse(s) to the care of another licensed trainer, and upon such approved transfer, such horse(s) may be entered to race. Upon transfer of such horse(s), the inactive trainer must not be involved in any arrangements related to the care, custody or control of the horse(s) and must not benefit financially or in any other way from the training of the horse(s).

(29) Ensuring that all individuals in their employ are properly licensed by the commission.

b. Restrictions on wagering. A trainer with a horse(s) entered in a race may wager only on that horse(s) or that horse(s) in combination with other horses.

10.6(2) *Assistant trainers.*

a. Upon the demonstration of a valid need, a trainer may employ an assistant trainer as approved by the stewards. The assistant trainer must be licensed prior to acting in such capacity on behalf of the trainer.

b. Qualifications for obtaining an assistant trainer's license will be prescribed by the stewards and the commission and may include requirements set forth in 491—Chapter 6.

c. An assistant trainer may substitute for and assume the same duties, responsibilities and restrictions as are imposed on the licensed trainer, in which case the trainer is jointly responsible for the assistant trainer's compliance with the rules.

10.6(3) *Substitute trainers.*

a. A trainer absent for more than five days from responsibility as a licensed trainer, or on a day in which the trainer has a horse in a race, must obtain another licensed trainer to substitute.

b. A substitute trainer must accept responsibility for the horses in writing and must be approved by the stewards.

c. A substitute trainer and the absent trainer are jointly responsible as absolute insurers of the condition of their horses entered in an official workout or race.

491—10.7(99D) Jockeys, apprentice jockeys, and jockey agents.

10.7(1) *Jockey responsibility.*

a. A jockey shall give a best effort during a race, and each horse shall be ridden to win.

b. A jockey cannot have a valet attendant except one provided and compensated by the facility.

c. No person other than the licensed contract employer or a licensed jockey agent may make riding engagements for a rider, except that a jockey not represented by a jockey agent may make the jockey's own riding engagements.

d. A jockey may have no more than one jockey agent.

e. No revocation of a jockey agent's authority is effective until the jockey notifies the stewards in writing of the revocation of the jockey agent's authority.

f. A jockey must promptly report objections to the outrider(s) following the finish of the race.

10.7(2) *Jockey betting.* A jockey may wager only on a race in which the jockey is riding. A jockey may wager only if:

a. The owner or trainer of the horse that the jockey is riding makes the wager for the jockey;

b. The jockey only wagers on the jockey's own mount to win or finish first in combination with other horses in multiple-type wagers; and

c. Records of such wagers are kept and available for presentation upon request by the stewards.

10.7(3) *Jockey's spouse.* A jockey cannot compete in any race against a horse that is trained or owned by the jockey's spouse.

10.7(4) *Fees and engagements.*

a. Duty to fulfill engagements. Jockeys must fulfill their duly scheduled riding engagements unless excused by the stewards. Jockeys cannot be forced to ride a horse they believe to be unsound or over a racing strip they believe to be unsafe. If the stewards find a jockey's refusal to fulfill a riding engagement is based on personal belief unwarranted by the facts and circumstances, the jockey may be subject to disciplinary action. Jockeys are responsible to their agent for any engagements previously secured by the agent.

b. Entitlement. Any apprentice or contract rider is entitled to the regular jockey fees, except when riding a horse owned in part or solely by the contract holder. An interest in the winnings only (such as trainer's percent) does not constitute ownership.

c. Fee earned. A jockey's fee is considered earned when the jockey is weighed out by the clerk of scales. The fee is not considered earned when injury to the horse or rider is not involved and jockeys, of their own free will, take themselves off their mounts. Any conditions or considerations not covered by the above are at the discretion of the stewards.

d. Multiple engagements. If any owner or trainer engages two or more jockeys for the same race, the owner or trainer is required to pay each of the jockeys the appropriate fee whether the jockeys ride in the race or not.

e. Competing engagements. Whenever two or more licensees claim the services of one jockey for a race, first call has priority and any dispute may be resolved by the stewards.

f. Dead heats. Jockeys finishing a race in a dead heat will divide equally the totals they individually would have received had one jockey won the race alone. The owners of the horses finishing in the dead heat will pay equal shares of the jockey fees.

10.7(5) *Jockey conduct.*

a. Clothing and appearance. A jockey wears the racing colors furnished by the owner of the horse the jockey is to ride, plus solid white riding pants, top boots, and a number on the right shoulder on the saddlecloth corresponding to the mount's number given as shown on the saddlecloth and in the daily program. The stewards, at their discretion, may allow a jockey to wear solid black riding pants during poor weather or track conditions. The Jockeys' Guild logo, the Permanently Disabled Jockeys Fund logo, or the jockey's name may be displayed on the pants. The size of the display of the jockey's name on the pants is limited to a maximum of 32 square inches on each thigh of the pants on the outer sides between the hip and the knee, and 10 square inches on the rear at the base of the spine. A jockey cannot wear advertising or promotional material of any kind on clothing during a race, unless the following criteria are met:

(1) A maximum of 32 square inches on each thigh of the pants on the outer side between the hip and knee and 10 square inches on the rear of the pant at the waistline at the base of the spine.

(2) A maximum of 24 square inches on boots and leggings on the outside of each nearest the top of the boot.

(3) A maximum of 6 square inches on the front center of the neck area (on a turtleneck or other undergarment).

(4) Such advertising or promotional material does not compete with, conflict with, or infringe upon any current sponsorship agreement to the racing association race or race meet.

(5) The stewards, at their discretion, may disallow any advertising that is not in compliance with this rule, any other rules of racing, or any advertising the stewards deem to be inappropriate, indecent, in poor taste, or controversial.

b. Competing against contractor. No jockey may ride in any race against a starting horse belonging to the jockey's contract employer unless the jockey's mount and the contract employer's horse are both trained by the same trainer.

c. Confined to jockey room. Jockeys engaged to ride a race must report to the jockey room on the day of the race at the time designated by the facility officials. The jockeys then report their engagements and any overweight to the clerk of scales. Thereafter, they cannot leave the jockey room, except by permission of the stewards, until all of their riding engagements of the day have been fulfilled. Once jockeys have fulfilled their riding engagements for the day and have left the jockeys' quarters, they will not be readmitted to the jockeys' quarters until after the entire racing program for that day has been completed, except upon permission of the stewards. Jockeys are not allowed to communicate with anyone but the trainer while in the room during the performance except with approval of the stewards. On these occasions, they will be accompanied by a security guard.

d. Whip prohibited. Jockeys cannot use a whip on a two-year-old horse before April 1 of each year, nor can a jockey or other person engage in excessive or indiscriminate whipping of any horse at any time.

e. Spurs prohibited. Jockeys cannot use spurs.

f. Possessing drugs or devices. Jockeys must not have in their care, control, or custody any drugs, prohibited substances, or electrical or mechanical device that could affect a horse's racing performance.

10.7(6) *Jockey effort.* A jockey must exert every effort to ride the horse to the finish in the best and fastest run of which the horse is capable. No jockey may ease up or coast to a finish, without adequate cause, even if the horse has no apparent chance to win prize money.

10.7(7) *Riding interference and riding infractions.*

a. When the way is clear in a race, a horse may be ridden to any part of the course, but if any horse swerves, or is ridden to either side, so as to interfere with, impede, or intimidate any other horse, it is a foul.

b. The offending horse may be disqualified if, in the opinion of the stewards, the foul altered the finish of the race, regardless of whether the foul was accidental, willful, or the result of careless riding. When a horse causes interference under this rule, every horse in the same race entered by the same owner or trainer who benefited from the interference may be disqualified at the discretion of the stewards.

c. If the stewards determine the foul was intentional, or due to careless riding, the jockey will be held responsible.

d. In a straightaway race, every horse must maintain position as nearly as possible in the lane in which it started. If a horse is ridden, drifts, or swerves out of its lane in such a manner that it interferes with, impedes, or intimidates another horse, it is a foul and may result in the disqualification of the offending horse.

e. Partial fault/third-party interference. If a horse or jockey interferes with or jostles another horse, the aggressor may be disqualified, unless the interfered or jostled horse or jockey was partly at fault or the infraction was wholly caused by the fault of some other horse or jockey.

f. Careless riding. A jockey must not ride carelessly or willfully permit the mount to interfere with, intimidate, or impede any other horse in the race. A jockey must not strike at another horse or jockey so as to jostle, impede, interfere with, or injure or potentially injure the other horse or jockey. If a jockey rides in a manner contrary to this rule, the horse may be disqualified; the jockey may be fined, suspended, or otherwise disciplined; or other penalties may apply.

10.7(8) *Jockey weighing.*

a. Jockeys must be weighed for their assigned horse not more than 30 minutes before the time fixed for the race.

b. A jockey's weight includes the jockey's clothing, boots, and saddle and its attachments. A safety vest is mandatory and must be consistent with subrule 10.2(9).

c. All other equipment is excluded from the weight.

d. Overweight limited. No jockey may weigh more than two pounds or, in the case of inclement weather, four pounds over the weight the horse is assigned to carry unless with consent of the owner or trainer and unless the jockey has declared the amount of overweight to the clerk of scales at least 60 minutes before the scheduled post time of the first race. However, a horse cannot carry more than seven pounds overweight, except in inclement weather when nine pounds is allowed. The overweight will be publicly announced and posted in a conspicuous place both prior to the first race of the day and before the running of the race.

(1) Weigh in. Upon completion of a race, jockeys must ride promptly to the winner's circle and dismount. Jockeys riding the first four finishers, or at the discretion of the stewards a greater number, must present themselves to the clerk of scales to be weighed in. If a jockey is prevented from riding the mount to the winner's circle because of accident or illness either to the jockey or the horse, the jockey may walk or be carried to the scales unless excused by the stewards.

(2) Unsaddling. Jockeys, upon completion of a race, must return to the unsaddling area and unsaddle their own horse, unless excused by the stewards.

(3) Removing horse's equipment. No person except the valet attendant for each mount may assist the jockey in removing the horse's equipment that is included in the jockey's weight, unless the stewards permit otherwise. To weigh in, jockeys carry to the scales all pieces of equipment with which they weighed out. Thereafter they may hand the equipment to the valet attendant.

(4) Underweight. When any horse places first, second, or third in a race and thereafter the horse's jockey is weighed in short by more than two pounds of the weight of which the jockey was weighed out, the mount may be disqualified and all purse moneys forfeited.

(5) Overweight. If the jockey is overweight, the jockey is subject to fine, suspension, or both.

10.7(9) *Jockey fines and forfeitures.* Jockeys must pay any fine or forfeiture from their own funds within 48 hours of the imposition of the fine or at a time deemed proper by the stewards. No other person may pay jockey fines or forfeitures for the jockey.

10.7(10) *Jockey suspension.*

a. Offenses involving fraud. Suspension of a licensee for an offense involving fraud or deception in racing begins immediately after the ruling unless otherwise ordered by the stewards or commission.

b. Offenses not involving fraud. Suspension for an offense not involving fraud or deception in racing begins on the third day after the ruling or at the stewards' discretion.

c. Withdrawal of appeal. Withdrawal by the appellant of a notice of appeal filed with the commission, whenever imposition of the disciplinary action has been stayed or enjoined pending a final decision by the commission, is deemed a frivolous appeal and referred to the commission for further disciplinary action in the event the appellant fails to show good cause to the stewards why the withdrawal should not be deemed frivolous.

d. Riding suspensions of ten days or less and participating in designated races. The stewards appointed for a race meeting will, prior to the commencement of that meeting, designate the stakes, futurities, futurity trials, or other races in which a jockey will be permitted to compete, notwithstanding the fact that such jockey is under suspension for ten days or less for a careless riding infraction at the time the designated race is to be run.

(1) Official rulings for riding suspensions of ten days or less will state: "The term of this suspension does not prohibit participation in designated races."

(2) A listing of the designated races will be posted in the jockey room and any other such location deemed appropriate by the stewards.

(3) A suspended jockey must be named at time of entry to participate in any designated race.

(4) A day in which a jockey participated in one designated race while on suspension counts as a suspension day. If a jockey rides in more than one designated race on a race card while on suspension, the day does not count as a suspension day. Each designated trial race for a stake is considered one race. A jockey who rides in more than one designated race may be named to ride other races on a card, and such race card does not count as a suspended race day.

10.7(11) *Apprentice jockeys.* Unless excepted under these rules, apprentices are subject to all rules governing jockeys and racing.

a. Upon completion of licensing requirements, the stewards may issue an apprentice jockey certificate allowing the holder to claim a weight allowance only in overnight races.

b. Apprentice jockey weight allowance.

(1) An apprentice jockey may ride with a five-pound weight allowance beginning with the first mount and continuing for one full year from the date of the jockey's fifth winning mount.

(2) If, after riding one full year from the date of the fifth winning mount, the apprentice jockey has not ridden 40 winners, the applicable weight allowance continues for one more year or until the fortieth winner, whichever comes first. A weight allowance cannot be claimed for more than two years from the date of the fifth winning mount, unless an extension has been granted.

(3) The stewards may extend the weight allowance of an apprentice jockey in their discretion upon proof of the apprentice's incapacitation for a period of seven or more consecutive days. The allowance may be claimed for a period not to exceed the period such apprentice was unable to ride.

(4) The apprentice jockey is responsible for possessing the apprentice certificate at all times and for keeping an updated record of the first 40 winners. Prior to riding, the jockey submits the certificate to the clerk of scales, who will record the apprentice's winning mounts.

10.7(12) *Jockey agent.*

a. Responsibilities.

(1) A jockey agent cannot make or assist in making engagements for a jockey other than the jockeys the agent is licensed to represent.

(2) A jockey agent must file written proof of all agencies and changes of agencies with the stewards.

(3) A jockey agent must notify the stewards, in writing, prior to withdrawing from representation of a jockey and submit to the stewards a list of any unfulfilled engagements made for the jockey. A jockey agent cannot withdraw from the representation of any jockey unless written notice to the stewards has been provided.

(4) All persons permitted to make riding engagements must maintain current and accurate records of all engagements made. Such records are subject to examination by the stewards at any time.

(5) No jockey agent may represent more than three jockeys during any single race card, as specified below:

1. During a mixed race card or quarter horse race card, a jockey agent may represent up to three jockeys who ride only quarter horses.

2. During a mixed race card or thoroughbred race card, a jockey agent may represent up to two jockeys who ride thoroughbreds, and one apprentice jockey.

(6) A jockey agent must honor a first call given to a trainer or the trainer's assistant trainer.

b. Prohibited areas. A jockey agent is prohibited from entering the jockey room, winner's circle, racing strip, paddock, or saddling enclosure during the hours of racing unless advance written permission has been granted from the stewards.

491—10.8(99D) Conduct of races.

10.8(1) *Horses ineligible.* Any horse ineligible to be entered for a race, or ineligible to start in any race, that competes in that race may be disqualified and the stewards may discipline the persons responsible for the horse competing in that race.

a. A horse is ineligible to enter a race when:

(1) The nominator has failed to identify the horse that is being entered for the first time, by name, color, sex, age, and the names of sire and dam as registered.

(2) A horse has been knowingly entered or raced in any jurisdiction under a different name, with an altered registration certificate, altered microchip, or altered lip or digital tattoo by a person having lawful custody or control of the horse for the purpose of deceiving any facility or regulatory agency.

(3) A horse has been allowed to enter or start by a person having lawful custody or control of the horse who participated in or assisted in the entry or racing of some other horse under the name of the horse in question.

(4) A horse is wholly or partially owned by a disqualified person or a horse is under the direct or indirect management of a disqualified person.

(5) A horse is wholly or partially owned by the spouse of a disqualified person or a horse is under the direct or indirect management of the spouse of a disqualified person. In such cases, a presumption that may be rebutted is that the disqualified person and spouse constitute a single financial entity with respect to the horse.

(6) A horse is owned in whole or in part by an undisclosed person or interest.

(7) A horse has been nerved by surgical neurectomy.

(8) A horse has been trachea-tubed to artificially assist breathing.

(9) A horse has impaired eyesight in both eyes.

(10) A horse appears on the Iowa veterinarian's list, notwithstanding a horse appearing on the veterinarian's list as a "bleeder." In addition, a horse appearing on any starter's, stewards', or paddock judge's list, or the veterinarian's list in another jurisdiction, is ineligible unless the horse is removed from the list by the day of the race and approved by the board of stewards to enter.

(11) A horse is barred from racing in any racing jurisdiction.

(12) A horse under four years of age has been injected with bisphosphonates. A horse four years of age or older may only be administered bisphosphonate if the bisphosphonate is Food and Drug Administration-approved for use in the horse, is for a diagnosed case of navicular disease, and is administered in accordance with the label requirements. If bisphosphonate is administered as permitted by rule, the commission must be notified within 24 hours of the administration. If bisphosphonate is detected in sampling or if a horse is administered bisphosphonate, the horse will be placed on the veterinarian's list for no less than six months.

(13) A horse has had any intra-articular joint injection within the past six days. When counting the number of days a horse is ineligible to run following an intra-articular injection, the day of injection is the first day. The detection of two or more corticosteroids constitutes a stacking violation.

(14) A horse has been administered thyroxine and thyroid modulators/hormones, including but not limited to those containing T4 (tetraiodothyronine/thyroxine), T3 (triiodothyronine), or combinations thereof. This excludes a horse that has been individually prescribed thyroxine and thyroid modulators/hormones.

b. A horse is ineligible to start a race when:

(1) The horse is not stabled on the premises of the facility by the time designated by the stewards.

(2) The horse's breed registration certificate is not on file, physically or digitally, with the racing secretary, or horse identifier, except where the racing secretary has submitted the certificate to the breed registry for correction or transfer of ownership. The stewards may, in their discretion, waive the requirement provided the registration certificate is in the possession of another board of stewards, a copy of the registration certificate is on file with the racing secretary, and the horse is otherwise properly identified. For claiming races, if the claimed horse has been approved by the stewards to run without the registration certificate on file in the racing office, then the registration certificate must be provided to the racing office within seven business days for transfer to the new owner before claiming funds will be approved for transfer by the stewards.

(3) The horse is not fully identified by an official tattoo on the inside of the upper lip or digital tattoo or microchip.

(4) A horse is brought to the paddock and is not in the care of and saddled by a currently licensed trainer or assistant trainer unless excused by the stewards.

(5) No current negative Coggins test or current negative equine infectious anemia test certificate is attached to the horse's registration certificate or otherwise accessible by the commission or racing association.

(6) The stakes or entrance money for the horse has not been paid.

(7) The horse appears on the starter's list, stewards' list, paddock list, or veterinarian's list, including as a bleeder.

(8) The horse is a first-time starter not approved by the starter and does not have a minimum of two official workouts for quarter horses or a minimum of three official workouts for thoroughbreds.

(9) Within the past calendar year, the horse has started in a race that has not been reported in a nationally published monthly chartbook, unless, at least 48 hours prior to entry, the owner of the horse provides to the racing secretary performance records that show the place and date of the race, distance, weight carried, amount carried, and the horse's finishing position and time.

(10) In a stakes race, a horse has been transferred with its engagements, unless prior to the start, the fact of transfer of the horse and its engagements has been filed with the racing secretary.

(11) A horse is subject to a lien that has not been approved by the stewards and filed with the horsemen's bookkeeper.

(12) A horse is subject to a lease not filed with the stewards.

(13) A horse is not in sound racing condition.

(14) A horse has been blocked with alcohol or injected with any other foreign substance or drug to desensitize the nerves of the leg.

(15) A thoroughbred has shoes (racing plates) that have toe grabs with a height greater than two millimeters (0.07874 inches), bends, jars, caulks, stickers or any other traction device on the front hooves while racing or training on all racing surfaces.

(16) A quarter horse has front shoes that have toe grabs with a height greater than four millimeters (0.15748 inches), bends, jars, caulks, stickers or any other traction device worn on the front shoes.

10.8(2) *Entries.*

a. The facility provides forms for making entries and declarations with the racing secretary. Entries and declarations must be in writing, or by telephone or fax subsequently confirmed in writing by the owner, trainer, or licensed designee. When any entrant or nominator claims failure or error in the receipt by a facility of any entry or declaration, the entrant or nominator may be required to submit evidence within a reasonable time of the filing of the entry or the declaration. Individuals who hold a jockey agent license, regardless of other licenses held, are not permitted to make entries after a time set by the stewards.

b. Upon the closing of entries the racing secretary will promptly compile a list of entries and cause it to be conspicuously posted.

c. Coupling. There will be no coupled entries in any race. In races, excluding stakes races, that overfill, trainers must declare preference of runners with identical ownership at time of entry. Same-owner, second-choice horses will be least preferred. A trainer, owner or licensed designee cannot enter more than three horses in a race unless the race is split or divided.

d. Split or divided races.

(1) In the event a race is canceled or declared off, the facility may split any overnight race for which post positions have not been drawn.

(2) Where an overnight race is split, forming two or more separate races, the racing secretary will give notice of not less than 15 minutes before such races are closed to grant time for making additional entries to each split race.

(3) A trainer may enter more than the maximum number of entries allowed under paragraph 10.8(2) *"c"* if the entries are declared at time of entry as "split entry only" and preference is given by the trainer for the trainer's first three entries.

(4) The racing secretary will split an overnight race so that common ownership, identical ownership, or common trainers will divide as equally as possible between two or more races.

e. Entry weight. Owners, trainers, or any other duly authorized person who enters a horse for a race should ensure the entry is correct and accurate as to the weight allowances available and claimed for the horse under the conditions set for the race. After a horse is entered and has been assigned a weight to carry in the race, the assignment of weight will not be changed except in the case of error and with the stewards' approval. Weight allowances may be waived with the approval of the stewards.

f. Consecutive days. No horse may run twice within four consecutive calendar days. For the purpose of this rule, the day after the start is the first day.

g. Foreign entries. For the purposes of determining eligibility, weight assignments, or allowances for horses imported from a foreign nation, the racing secretary will take into account the standards established by the European Pattern Committee and the International Federation of Horseracing Authorities (IFHA).

h. Weight conversions. For the purpose of determining eligibility, weight assignments, or allowances for horses imported from a foreign nation, the racing secretary will convert metric distances to English measures by reference to the following scale:

1 sixteenth	= 100 meters
1 furlong	= 200 meters
1 mile	= 1600 meters

i. Name. The "name" of a horse means the name reflected on the certificate of registration, racing permit, or temporary racing permit issued by the breed registry. Imported horses must have a suffix, enclosed by brackets, added to their registered names showing the country of foaling. This suffix is derived from the international code of suffixes and constitutes part of the horse's registered name. The registered names and suffixes, where applicable, will be printed in the official program.

j. Bona fide entry. No person may enter or attempt to enter a horse for a race unless that entry is a bona fide entry, made with the intention that the horse is to compete in the race for which the horse was entered.

k. Registration certificate to reflect correct ownership. Every breed registry foal certificate filed physically or digitally with the racing secretary to establish the eligibility of a horse to be entered for any race must accurately reflect the correct and true ownership of the horse. The name of the owner that is printed on the official program for the horse must conform to the ownership as declared on the certificate of registration or eligibility certificate unless a stable name has been registered with the commission for the owner or ownership.

l. Naming/engaging of riders. Riders are named at the time of entry. If, at the conclusion of the draw of a race, a trainer does not have a rider, all riders who are available will be made known to the trainer at that time via telephone or in person by the stewards or their designee. A trainer who does not name a rider prior to the conclusion of the draw of a race, and reasonable attempts have been employed to contact the trainer with no response, will have an available rider engaged at the facility placed on the horse, determination of which will be drawn by lot. Riders properly engaged as a first or second call in a race must fulfill their engagements as required in subrule 10.7(4).

m. More than one race. No horse may be entered in more than one race, with the exception of stakes races, to be run on the same day on which pari-mutuel wagering is conducted.

n. Iowa-foaled horse. An Iowa-foaled horse cannot enter a race limited to Iowa-foaled horses unless the horse is registered with and the papers are either physically or digitally stamped by the department of agriculture and land stewardship. An Iowa-foaled horse may run in an open race without the stamp but is ineligible for Iowa-bred supplement, Iowa-bred breeders awards, and Iowa-bred breeders supplement.

10.8(3) *Sweepstakes entries.*

a. Entry and withdrawal. The entry of a horse in a sweepstakes is a subscription to the sweepstakes. Before the time of closing, any entry or subscription may be altered or withdrawn.

b. Entrance money. Entrance money is paid by the nominator to a race. In the event of the death of the horse or a mistake made in the entry of an otherwise eligible horse, the nominator subscriber continues to be obligated for any stakes, and the entrance money will not be returned.

c. Quarter horse scratches and qualifiers unable to participate in finals. If a horse is scratched from the time trial finals, the horse's owner is not eligible for a refund of the fees paid. If a horse that qualified for the final is unable to enter due to racing soundness, or scratched for any reason other than a positive drug test report or a rule violation, the horse will be deemed to have earned, and the owner will receive, last place money. If more than one horse is unable to enter due to racing soundness, or

is scratched for any reason other than a positive drug test report or a rule violation, then those purse moneys will be added together and divided equally among the horse owners.

10.8(4) *Closing of entries.*

a. Overnight entries. The racing secretary will close entries for overnight racing at 10 a.m. unless the racing secretary establishes or the stewards approve a later closing.

b. Sweepstakes entries. If an hour for closing is designated, entries and declarations for sweepstakes cannot be received thereafter. However, if a time for closing is not designated, entries and declarations may be mailed or faxed until midnight of the day of closing, if they are received in time to comply with all other conditions of the race. In the absence of notice to the contrary, entries and declarations for sweepstakes that close during or on the day preceding a race meeting will close at the office of the racing secretary in accordance with any requirements the secretary sets. Closing for sweepstakes not during race meetings will be at the office of the facility.

c. Exception. Nominations for stakes races will not close, nor will any eligibility payment be due, on a day when the United States Postal Service is not operating.

10.8(5) *Prohibited entries.*

a. Entry by disqualified person. An entry made by a disqualified person or the entry of a disqualified horse is void. Any money paid for the entry will be returned, if the disqualification is disclosed at least 45 minutes before post time for the race. Otherwise, the entry money will be paid to the winner.

b. Limited partner entry prohibited. No person other than a managing partner of a limited partnership or a person authorized by the managing partner may enter a horse owned by that partnership.

c. Altering entries prohibited. No alteration may be made in any entry after the closing of entries, but the stewards may permit the correction of an error in an entry.

d. Limitation on overnight entries. If the number of entries to any purse or overnight race is in excess of the number of horses that may be accommodated due to the size of the track, the starters for the race and their post positions will be determined by lot conducted in public by the racing secretary.

e. Stake race entry limit. In a stake race, the number of horses that may compete is limited only by the number of horses nominated and entered. In any case, the facility's lawful race conditions govern.

f. Stewards' denial of entry. The stewards may, after notice to the entrant, subscriber, or nominator, deny entry of any horse to a race if the stewards determine the entry to be in violation of these rules or the laws of this state or to be contrary to the interests of the commission in the regulation of pari-mutuel wagering or to public confidence in racing.

10.8(6) *Preferences and eligibles.*

a. Also eligible. A list of no more than eight names may be drawn from entries filed in excess of positions available in the race. These names will be listed as "also eligible" to be used as entries if originally entered horses are withdrawn. Any owner, trainer, or authorized agent who has entered a horse listed as an "also eligible" and who does not wish to start will file a scratch card with the secretary not later than the scratch time designated for that race. "Also eligibles" have preference to scratch.

b. Preference system. A system using dates or stars will be used to determine preference for horses being entered in races. The system used is at the option of the racing secretary and approved by the stewards. A preference list will be kept current by the racing secretary and made available to horsemen upon request.

c. Disputed decision. When the decision of a race is in dispute, all horses involved in the dispute, with respect to the winner's credit or earnings, are liable to all weights or conditions attached to the winning of that race until a winner has been finally adjudged.

10.8(7) *Post positions.* Post positions will be determined by the racing secretary publicly and by lot. Post positions will be drawn from "also eligible" entries at scratch time. In all races, horses drawn into the race from the "also eligible" list take the outside post positions, except in straightaway quarter horse racing. In straightaway quarter horse racing, the post position of the scratched horse is assigned to the horse "drawing in." If there is more than one scratch, the post positions will be assigned by lot.

10.8(8) *Scratch; declaring out.*

a. Notification to the secretary. No horse is considered scratched, declared out, or withdrawn from a race until the owner, agent, or other authorized person has given notice in writing to the racing secretary before the time set by the facility as scratch time. All scratches must be approved by the stewards.

b. Declaration irrevocable. Scratching or the declaration of a horse out of an engagement for a race is irrevocable.

c. Limitation on scratches. No horse may be scratched from a race if the horses remaining in the race number fewer than seven betting interests, unless the stewards permit a lesser number. When the number of requests to scratch would, if granted, leave a field of fewer than seven, the stewards will determine by lot which entrants may be scratched and permitted to withdraw from the race. Veterinarian scratches will be preferred and accepted without regard to the number of entries.

d. Scratch time. Unless otherwise set by the stewards, scratch times are as follows:

(1) Stakes races. Scratch time will be at least 45 minutes before post time.

(2) Other races. Scratch time will be set by the stewards prior to the start of the meet.

10.8(9) *Workouts.*

a. Thoroughbreds, when required.

(1) No horse may start unless the horse has raced in an official race or has had an approved official timed workout satisfactory to the stewards, and adheres to the following for horses that are not first-time starters:

1. A horse that has not started for a period of 60 days or more must have had an official workout satisfactory to the stewards prior to the day of the race in which the horse started, and the horse must have had an official workout within the previous 30 days.

2. A horse that has not started for a period of 180 days or more must have had two official workouts, one of which must have occurred within the previous 30 days prior to the day of the race in which the horse started.

3. A horse that has not started for a period of 365 days or more must fulfill the following requirements before being allowed to start:

- The horse must have had three official workouts.
- One of the three official workouts must have been from the starting gate going at least one-half mile, within 60 days of starting.

(2) No first-time starter may race unless it has had three official workouts, with one having occurred from the gate within the previous 60 days, and is approved to start from the gate by the starter.

b. Quarter horses, when required.

(1) No horse may start unless the horse has raced in an official race or has had an approved official timed workout satisfactory to the stewards, and adheres to the following for horses that are not first-time starters:

1. A horse that has not started for a period of 60 days or more is ineligible to race until it has had an official workout satisfactory to the stewards prior to the day of the race in which the horse started, and the horse must have had an official workout within the previous 60 days.

2. A horse that has not started for a period of 180 days or more must have had two official workouts, one of which must have occurred within the previous 60 days.

3. A horse that has not started for a period of 365 days or more must fulfill the following requirements before being allowed to start:

- The horse must have had two official workouts.
- One of the two official workouts must have been from the starting gate within 60 days of starting.

(2) No first-time starter may race unless it has had two official workouts, with one having occurred from the gate within the previous 60 days, and is approved to start from the gate by the starter.

c. Counting of days. For the purpose of counting the number of days a horse is ineligible to start, the day after the workout is the first day.

d. Identification. The timer or the stewards may require licensees to identify a horse in their care being worked. The owner, trainer, or jockey may be required to identify the distance the horse is to be worked and the point on the track where the workout will start.

e. Information dissemination. If the stewards approve the timed workout so as to permit the horse to run in a race, they will require this information to be furnished to the public in advance of the race, including but not limited to the following means:

(1) Announcement over the facility's public address system;

(2) Transmission on the facility's message board;

(3) Posting in designated conspicuous places in the racing enclosure; and

(4) Exhibit on track TV monitors at certain intervals if the track has closed circuit TV. If the workout is published prior to the race in either the Daily Racing Form or the track program, then it is not necessary to make the announcements set forth above.

f. Restrictions. No horse may be taken onto the track for training or a workout except during hours designated by the facility.

10.8(10) *Equipment.*

a. Whip and bridle limitations. Unless permitted by the stewards, no whip or substitute for a whip may exceed one pound or 30 inches, and no bridle may exceed two pounds.

b. Equipment change. No licensee may change the equipment used on a horse from that used in the horse's last race, unless with permission of the stewards. No licensee may add blinkers or cheek pieces to a horse's equipment, or discontinue their use, without the prior approval of the starter. First-time starters must race with or without blinkers or cheek pieces in accordance with the gate approval card issued by the starter. In the paddock prior to a race, a horse's tongue may be tied down with clean bandages, clean gauze, or with a tongue strap.

10.8(11) *Racing numbers and silks.*

a. Number display. Each horse in a race will carry a conspicuous saddle cloth number corresponding to the official number given that horse on the official program.

b. Field horses. In a combined field of horses, each horse in the field will carry a separate number.

c. Racing silks. Racing silks are turned in to the racing office or jockey room custodian upon arrival to the facility.

(1) All horses running in a race must race in an owner's silk or trainer's silk.

(2) In the case of a partnership, the horse will run with a managing partner's silk or a trainer's silk if no partnership silk is available.

(3) Under special circumstances, the stewards in their discretion may permit a horse to run in a house silk.

10.8(12) *Dead heats.*

a. When two horses run a dead heat for first place, all purses or prizes to which first and second horses would have been entitled will be divided equally between them; this applies in dividing all purses or prizes whatever the number of horses running a dead heat and whatever places for which the dead heat is run.

b. In the event of a dead-heat finish for second place and thereafter, when an objection to the winner of the race is sustained, the horses in the dead heat are considered to have run a dead heat for first place.

c. If a prize includes a cup, plate, or other indivisible prize, owners will draw lots for the prize in the presence of at least two stewards.

10.8(13) *Equine infectious anemia (EIA) test.*

a. Certificate required. No horse may start or be stabled on the premises of the facility unless a valid negative Coggins test or other laboratory-approved negative EIA test certificate is on file with the racing secretary.

b. Trainer responsibility. In the event of claims, sales, or transfers, it is the new trainer's responsibility to ascertain the validity of the certificate for the horse within 24 hours. If the certificate is either unavailable or invalid, the previous trainer is responsible for any reasonable cost associated with obtaining a negative EIA laboratory certificate.

c. Positive test reports. Whenever any owner or trainer is furnished a positive Coggins test or positive EIA test result, the horse must be removed by the owner or trainer from facility premises or approved farms within 24 hours of actual notice to the owner or trainer of the infection.

10.8(14) *Race procedures.*

a. Full weight. Each horse must carry the full weight assigned for that race from the paddock to the starting point and will parade past the stewards' stand, unless excused by the stewards.

b. Touching and dismounting prohibited. After the horses enter the track, jockeys cannot dismount or entrust their horse to the care of an attendant unless due to an accident occurring to the jockey, the horse, or the equipment, and then only with the prior consent of the starter. During any delay during which a jockey is permitted to dismount, all other jockeys may dismount and their horses may be attended by others. After the horses enter the track, only the hands of the jockey, the starter, the assistant starter, the commission veterinarian, an outrider on a lead pony, or persons approved by the stewards may touch the horse before the start of the race. If a horse throws its jockey on the way from the paddock to the post, the horse must be returned to the point where the jockey was thrown, where the horse will be remounted and then proceed over the route of the parade to the post. The horse must carry its assigned weight from paddock to post and from post to finish.

c. Jockey injury. If a jockey is seriously injured on the way to the post, the horse will be returned to the paddock, a replacement jockey obtained, and both the injured jockey and the replacement jockey will be paid by the owner.

d. Twelve-minute parade limit. After entering the track, all horses will proceed to the starting post in not more than 12 minutes unless approved by the stewards. After passing the stewards' stand in parade, the horses may break formation and proceed to the post in any manner. Once at the post, the horses will be started without unnecessary delay. All horses must participate in the parade carrying their weight and equipment from the paddock to the starting post, and any horse failing to do so may be disqualified by the stewards. A lead pony leading a horse in the parade cannot obstruct the public's view of the horse being led except with permission of the stewards.

e. Striking a horse prohibited. In assisting the start of a race, no person other than the jockey, starter, assistant starter, or veterinarian may strike a horse or use any other means to assist the start.

f. Loading of horses. Horses will be loaded into the starting gate in numerical order or in any other fair and consistent manner determined by the starter and approved by the stewards.

g. Delays prohibited. No person may obstruct or delay the movement of a horse to the starting post.

10.8(15) *Claiming races.*

a. Eligibility.

(1) Registered to race or open claim. No person may file a claim for any horse unless the person:

1. Is a licensed owner at the meeting who either has foal paper(s) registered with the racing secretary's office or has started a horse at the meeting; or

2. Is a licensed authorized agent, authorized to claim for an owner eligible to claim; or

3. Has a valid open claim certificate. Any person not licensed as an owner, or a licensed authorized agent for the account of the same, or a licensed owner not having foal paper(s) registered with the racing secretary's office or who has not started a horse at the current meeting may request an open claim certificate from the commission. The person must submit a completed application for a prospective owner's license to the commission. The applicant must disclose or list the name of the trainer licensed by the commission who will be responsible for the claimed horse. A nonrefundable fee must accompany the application along with any financial information requested by the commission. The names of the prospective owners will be prominently displayed in the offices of the commission and the racing secretary. The application will be processed by the commission; and when the open claim certificate is exercised, an owner's license will be issued; or

4. Is not a family member related within the second degree of affinity or consanguinity to the person or ownership entity who owns the horse. For the purpose of determining whether an ownership entity is excluded from claiming a horse or having a horse claimed, a family member within the second degree of affinity or consanguinity means a parent, child, grandparent, grandchild, sibling, or in-law who owns or controls 5 percent or more of said entity.

(2) Number of claims.

1. An ownership entity (sole owner, partnership, limited liability partnership, racing stable, corporation, limited liability corporation, or owner/trainer acting as an owner) cannot claim more than one horse in a race. Any commonality of ownership prohibits more than one claim in a race by any of those entities.

2. An authorized agent or trainer acting on behalf of an ownership entity cannot submit more than two claims in a race with two separate ownership interests.

3. A trainer cannot receive more than two horses from any claiming race.

b. Procedure for claiming. To make a claim for a horse, an eligible person must:

(1) Deposit to the person's account with the horsemen's bookkeeper the full claiming price, as printed in the official program, and applicable taxes as established by the racing secretary's conditions.

(2) File in a locked claim box maintained for that purpose by the racing secretary the claim filled out completely in writing and with sufficient accuracy to identify the claim on forms provided by the facility at least ten minutes before the post time of the race.

c. Claim box.

(1) The claim box will be approved by the commission and kept locked until ten minutes prior to the start of the race, when it will be presented to the stewards or their representatives for opening and publication of the claims.

(2) The claim box will also include a time clock that automatically stamps the time on the claim envelope prior to its being dropped in the box.

(3) No official of a facility may give any information as to the filing of claims therein until after the race has been run.

d. Claim irrevocable. After a claim has been filed in the claim box, it cannot be withdrawn.

e. Multiple claims on single horses. If more than one claim is filed on a horse, the successful claim will be determined by lot conducted by the stewards or their representatives. After title to the claimed horse is determined by lot, all other claims on that horse are deemed null and void. If the winning claim determined by lot is subsequently ruled invalid for any reason, title to the horse will be returned to the owner of the horse prior to the lot draw. The successful claimant is responsible for all care and maintenance of the horse from the time the horse is transferred to the claimant until the time the horse is returned to the prior owner after invalidation of the claim.

f. Successful claims; later races.

(1) Sale or transfer. No successful claimant may sell or transfer a horse, except in a claiming race, for 30 days from the date of claim.

(2) Eligibility price. A horse claimed cannot start in a race in which the claiming price is less than the amount for which it was claimed. After 30 days, a horse may start for any claiming price. This provision does not apply to starter handicaps in which the weight to be carried is assigned by the handicapper or for starter allowances. No right, title, or interest for any claimed horse may be sold or transferred except in a claiming race for a period of 30 days following the date of claiming. To calculate the 30-day period, the day claimed does not count, and the following calendar day is the first day.

(3) Racing elsewhere. A horse that was claimed under these rules cannot participate at a race meeting other than that at which it was claimed until the end of the meeting, except with written permission of the stewards. This limitation does not apply to stakes races.

(4) Same management. A claimed horse cannot remain in the same stable or under the control or management of its former owner or trainer. No person may claim their own horse or cause their own horse to be claimed, directly or indirectly, for their own account.

(5) When a horse is claimed out of a claiming race, the horse's engagements are included.

g. Transfer after claim.

(1) Forms. Upon a successful claim, the stewards will issue in triplicate, on forms approved by the commission, an authorization of transfer of the horse from the original owner to the claimant. Copies of the transfer authorization will be forwarded to and maintained by the commission, the stewards, and the racing secretary.

(2) No claimed horse will be delivered by the original owner to the successful claimant until the claim is approved by the stewards. Every horse claimed races for the account of the original owner,

but title to the horse is transferred to the claimant at the moment the horse becomes a starter, and the successful claimant becomes the owner of the horse unless the claim is voided by the stewards. Only a horse that is officially a starter in the race may be claimed. A subsequent disqualification of the horse by order of the stewards has no effect upon the claim.

(3) The stewards will void the claim and return the horse to the original owner if:

1. The claimed horse suffers a fatality during the running of the race, dies, or is euthanized before leaving the track.

2. The commission veterinarian, during the veterinarian's observation of the horse coming off the track or upon its arrival to the test barn, determines the horse will be placed on the veterinarian's list. The stewards will not void the claim if, prior to the race in which the horse is claimed, the claimant elects to claim the horse regardless of whether the commission veterinarian determines the horse will be placed on the veterinarian's list. An election made under this rule will be entered on the claim form.

3. The race is called off, canceled, or declared no contest.

4. The proper credit balance has not been established with the horsemen's bookkeeper.

5. The claim is otherwise inconsistent with Iowa law and the commission's rules.

(4) Other-jurisdiction rules. The commission will recognize and be governed by the rules of any other jurisdiction regulating title and claiming races when ownership of a horse is transferred or affected by a claiming race conducted in that other jurisdiction.

(5) Determination of sex and age. The claimant, within 48 hours, is responsible for determining the age and sex of the horse claimed notwithstanding any designation of sex and age appearing in the program or in any racing publication. Horses that are spayed or gelded must be properly identified in the program. If the claimant finds that a mare is in fact spayed or that the status of a male horse is inaccurate as stated by the program, the claimant may return the horse for full refund of the claiming price.

(6) Affidavit by claimant. The stewards may, if they determine it necessary, require any claimant to execute a sworn statement that the claimant is claiming the horse for the claimant's own account or as an authorized agent for a principal and not for any other person.

(7) Delivery required. No person may refuse to deliver a properly claimed horse to the successful claimant. The claimed horse is disqualified from entering any race until delivery is made to the claimant.

(8) Obstructing the rules of claiming. No person or licensee may obstruct or interfere with another person or licensee in claiming any horse, enter into any agreement with another to subvert or defeat the object and procedures of a claiming race, or attempt to prevent any horse entered from being claimed.

h. Elimination of stable. An owner whose stable has been eliminated by claiming may claim for the remainder of the meeting at which eliminated or for 30 racing days, whichever is longer. With the permission of the stewards, stables eliminated by fire or other casualty may claim under this rule.

i. Disallowance of claim. The stewards may cancel and disallow any claim within 24 hours after a race if they determine that a claim was made upon the basis of a lease, sale, or entry of a horse made for the purpose of fraudulently obtaining the privilege of making a claim; or if an eligible claimant improperly obtains information or access to horses by being present in the paddock during the claiming race unless the claimant has a horse in that claiming race, as determined solely by the stewards. In the event of a disallowance, the stewards may further order the return of a horse to its original owner and the return of all claim moneys. To disallow a claim, it must be shown by clear and convincing evidence that there is a direct and substantial connection between the eligible claimant and the owner or owner's trainer of the horse to be claimed wherein the eligible claimant improperly gained information about the horse to be claimed and the information was otherwise unavailable to other licensed owners or ownership entities.

j. Protest of claim. A protest to any claim must be filed with the stewards before noon of the day following the date of the race in which the horse was claimed. Nonracing days are excluded from this rule. Should the stewards void a claim for reasons other than failure to follow the procedure for claiming, when there are multiple claims on a singular horse, said claim will not be voided until after the determination by lot.

k. Waived claiming rule. At the time of entry into claiming races, the owner, trainer, or any authorized agent may opt to declare a horse ineligible to be claimed provided:

(1) The horse has not been an official starter at any racetrack for a minimum of 120 days since the horse's last race as an official starter (at time of race);

(2) The horse's last race as an official starter was one in which the horse was eligible to be claimed;

(3) The horse is entered for a claiming price equal to or greater than the claiming price at which the horse last started as an official starter;

(4) Failure of declaration of ineligibility at time of entry cannot be remedied; and

(5) Ineligibility to be claimed applies only to the horse's first start as an official starter following each such 120-day or longer layoff.

l. Eligibility of in-foal filly or mare. An in-foal filly or mare is eligible to be entered into a claiming race only if the following conditions are fulfilled:

(1) Full disclosure of such fact is on file with the racing secretary and such information is posted in the secretary's office;

(2) The stallion service certificate has been deposited with the racing secretary's office before the horse runs;

(3) All payments due for the service in question and for any live progeny resulting from that service are paid in full;

(4) The release of the stallion service certificate to the successful claimant at the time of claim is guaranteed; and

(5) The cutoff for racing is 150 days of gestation.

10.8(16) *Quarter horse time trial races.*

a. Except in cases where the starting gate physically restricts the number of horses starting, each time trial will consist of no more than ten horses.

b. The time trials will be raced under the same conditions as the finals. If the time trials are conducted on the same day, the horses with the ten fastest times qualify to participate in the finals. If the time trials are conducted on two days, the horses with the five fastest times on the first day and the horses with the five fastest times on the second day qualify to participate in the finals. When time trials are conducted on two days, the racing office should make every attempt to split owners with more than one entry into separate days so that the owner's horses have a chance at all ten qualifying positions.

c. If the facility's starting gate has fewer than ten stalls, the maximum number of qualifiers will correspond to the maximum number of starting gate post positions.

d. If only 11 or 12 horses are entered to run in time trials from a gate with 12 or more stalls, the facility may choose to run finals only. If 11 or 12 horses participate in the finals, only the first 10 finishers will receive purse money.

e. In the time trials, horses qualify on the basis of time and order of finish. The times of the horses in the time trial will be determined to the limit of the timer. The only exception is when two or more horses have the same time in the same trial heat. Then the order of finish also determines the preference in the horses' qualifying for the finals. Should two or more horses in different time trials have the same qualifying time to the limit of the timer for the final qualifying position(s), then a draw by public lot will be conducted as directed by the stewards. Under no circumstances should stewards or placing judges attempt to determine horses' qualifying times in separate trials beyond the limit of the timer by comparing or enlarging a photo finish picture.

f. Except in the case of disqualification, under no circumstances will a horse qualify ahead of a horse that finished ahead of that horse in the official order of finish in a time trial.

g. Should a horse be disqualified for interference during the running of a time trial, it will receive the time of the horse it is immediately placed behind plus one hundredth of a second, or the maximum accuracy of the electronic timing device. No adjustments will be made in the times recorded in the time trials to account for headwind, tailwind, and off track. In the case where a horse is disqualified for interference with another horse causing loss of rider or the horse not to finish the race, the disqualified horse may be given no time plus one hundredth of a second, or the maximum accuracy of the electronic timing device.

h. Should a malfunction occur with an electronic timer on any time trial, finalists from that time trial will then be determined by official hand times operated by three official and disinterested persons.

The average of the three hand times will be utilized for the winning time, unless one of the hand times is clearly incorrect. In such cases, the average of the two accurate hand times will be utilized for the winning time. The other horses in that race will be given times according to the order and margins of finish with the aid of the photo finish strip, if available.

i. Unless the conditions of the stakes race provide otherwise, when there is a malfunction of the timer during the time trials, but the timer operates correctly in other time trials, the accurate electronic times should not be discarded in favor of the average of the hand times used for all time trials.

j. Where the accuracy of the electronic timer or the average of the hand times is questioned, the video of a time trial may be used to estimate the winning time by counting the number of video frames in the race from the moment the starting gate stall doors are fully open parallel to the racing track. This method is accurate to approximately .03 seconds. If the timer malfunctions and there are no hand times, the stewards have the option to select qualifiers based on the video time.

k. Should there be a malfunction of the starting gate and one or more stall doors not open or open after the exact moment when the starter dispatches the field, the stewards may declare the horses in stalls with malfunctioning doors to be nonstarters. The stewards have the option, however, to allow any horse whose stall door opened late but still ran a time fast enough to qualify to be declared a starter for qualifying purposes. If a horse breaks through the stall door or the stall door opens prior to the exact moment the starter dispatches the field, the horse will be declared a nonstarter and all entry fees refunded. If one or more, but not all, stall doors open at the exact moment the starter dispatches the field, these horses should be considered starters for qualifying purposes, and placed according to their electronic times. If the electronic timer malfunctions in this instance, the average of the hand times, or, if not available, the video time, should be utilized for the horses that were declared starters.

l. There will be an also eligible list only in the case of a disqualification for a positive drug test report, ineligibility of the horse according to the conditions of the race, or a disqualification by the stewards for a rule violation. Should a horse be disqualified for a positive drug test report, ineligibility of the horse according to the conditions of the race, or a disqualification by the stewards for a rule violation, the next fastest qualifier assumes the disqualified horse's position in the finals.

m. If a horse is scratched from the time trials, the horse's owner will not be eligible for a refund of the fees paid, and that horse will not be allowed to enter the finals under any circumstances. If a horse that qualified for the finals is unable to enter due to racing soundness or is scratched for any reason other than a positive drug test report or a rule violation, the horse is deemed to have earned, and the owner will receive, last place purse money. If more than one horse is scratched from the finals for any reason other than a positive drug test report or a rule violation, then the purse moneys will be added together and divided equally among the owners.

491—10.9(99D) Medication and administration, sample collection, chemists, and practicing veterinarian.

10.9(1) *Medication and administration.*

a. No horse, while participating in a race, may carry in its body any medication, drug, foreign substance, or metabolic derivative thereof, which is a narcotic or which could serve as a local anesthetic or tranquilizer or which could stimulate or depress the circulatory, respiratory, or central nervous system of a horse, thereby affecting its speed.

b. Any drugs or foreign substances that might mask or screen the presence of the prohibited drugs, or prevent or delay testing procedures, are also prohibited.

c. Proof of detection by the commission chemist of the presence of a medication, drug, foreign substance, or metabolic derivative thereof, prohibited by paragraph 10.9(1)*"a"* or *"b,"* in any bodily substances including but not limited to saliva, urine, blood, or hair sample duly taken under the supervision of the commission veterinarian from a horse immediately prior to or promptly after running in a race is prima facie evidence that the horse was administered, with the intent that it would carry or that it did carry in its body while running in a race, a prohibited medication, drug, or foreign substance in violation of this rule.

d. Administration or possession of drugs.

(1) No person shall administer, cause to be administered, or participate or attempt to participate in any way in the administration of any medication, drug, foreign substance, or treatment by any route to a horse registered for racing on the day of the race prior to the race in which the horse is entered.

(2) No person except a veterinarian shall have in the person's possession any prescription drug. Prescriptions must be written or dispensed or both only by duly licensed veterinarians in the context of a valid veterinarian-client-patient relationship and based upon a specific medical diagnosis. However, a person may possess a noninjectable prescription drug for animal use if all of the following are met:

1. The person actually possesses, within the racetrack enclosure, documentary evidence that a prescription has been issued to said person for such a prescription drug.

2. The prescription contains a specific dosage for the particular horse or horses to be treated by the prescription drug.

3. The horse or horses named in the prescription are in said person's care within the racetrack enclosure.

(3) No veterinarian or any other person shall have in their possession or administer to any horse within any racetrack enclosure any chemical or biological substance that:

1. Has not been approved for use on equines by the Food and Drug Administration pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. Section 301 et seq., and implementing regulations, without the prior written approval from a commission veterinarian, after consulting with the board of stewards.

2. Is on any of the schedules of controlled substances as prepared by the Attorney General of the United States pursuant to 21 U.S.C. Sections 811 and 812, without the prior written approval from a commission veterinarian after consultation with the board of stewards. The commission veterinarian will not give approval unless the person seeking the approval can produce evidence in recognized veterinary journals or by recognized equine experts that such chemical substance has a beneficial therapeutic use in horses.

(4) No veterinarian or any other person shall dispense, sell, or furnish any feed supplement, tonic, veterinary preparation, medication, or any other substance that can be administered or applied to a horse by any route, to any person within the premises of the facility unless it is labeled in conformance with this rule or is otherwise labeled as required by law. A substance does not comply with this rule if the label is missing, illegible, tampered with, or altered.

1. Labels for all substances must include the name of the substance dispensed; the name of the dispensing person; the name of the horse or horses for which the substance is dispensed; the purpose for which the substance is dispensed; the dispensing veterinarian's recommendations for withdrawal before racing, if applicable; and the name of the person to whom dispensed.

2. Labels for medications or other prescribed substances must include all items from paragraph 10.9(1)*"d"* and, in addition, the date the prescription was filled, name of the trainer or owner of the horse for whom the product was dispensed, dose, dosage, route of administration, duration of treatment of the prescribed product, and expiration date.

(5) No person shall have in the person's possession or in areas under said person's responsibility on facility premises any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route unless it complies with the labeling requirements in subparagraph 10.9(1)*"d"*(4).

(6) Unless approved by the commission veterinarian, no person shall possess, use, or distribute a compounded medication within the premises of the facility if there is a Food and Drug Administration-approved equivalent of that substance available for purchase. Veterinary drugs must be compounded in accordance with all applicable state and federal laws. Compounded medication may be dispensed only by prescription issued by a licensed veterinarian to meet the medical needs of a specific horse and for use only in that specific horse. All compound medications must be labeled as required by law.

(7) Any drug or medication for horses that is used or kept on facility premises and that requires a prescription must be prescribed in compliance with applicable state law and regulations by a veterinarian who is duly licensed by the commission, the Iowa veterinary board, or the state in which the horse was located at the time of the examination, diagnosis, and prescription.

e. Any person found to have administered, or caused, participated in, or attempted to participate in any way in the administration of a medication, drug, or foreign substance that caused or could have caused a violation of this rule is subject to disciplinary action.

f. The owner, trainer, groom, or any other person having charge, custody, or care of the horse is obligated to protect the horse properly and guard it against the administration or attempted administration of a substance in violation of this rule. If the stewards find that any person has failed to show proper protection and guarding of the horse, or if the stewards find that any owner, lessee, or trainer is guilty of negligence, they will impose discipline and take other action they deem proper under any of the rules, including referral to the commission.

g. In order for a horse to be placed on the bleeder list in Iowa through reciprocity, that horse must be certified as a bleeder in another state or jurisdiction. A certified bleeder is a horse that has raced with furosemide in another state or jurisdiction in compliance with the laws governing furosemide in that state or jurisdiction.

h. The possession or use of blood doping agents, including but not limited to those listed below, on the premises of a facility under the jurisdiction of the commission is forbidden:

(1) Erythropoietin;

(2) Darbepoetin;

(3) Oxyglobin®; and

(4) Hemopure®.

i. The use of extracorporeal shock wave therapy or radial pulse wave therapy is not permitted unless the following conditions are met:

(1) Any treated horse cannot race for a minimum of ten days following treatment;

(2) The use of extracorporeal shock wave therapy or radial pulse wave therapy machines is limited to veterinarians licensed to practice by the commission;

(3) Any extracorporeal shock wave therapy or radial pulse wave therapy machines on the association grounds must be registered with and approved by the commission or its designee before use;

(4) All extracorporeal shock wave therapy or radial pulse wave therapy treatments must be reported to the official veterinarian on the prescribed form not later than the time prescribed by the official veterinarian.

j. The use of a nasogastric tube longer than six inches for the administration of any substance within 24 hours prior to the post time of the race in which the horse is entered is prohibited without the prior permission of the official veterinarian or designee.

k. Nonsteroidal anti-inflammatory drugs (NSAIDs) in thoroughbreds.

(1) The use of one of three approved NSAIDs is permitted under the following conditions, unless preempted by federal law:

1. The level does not exceed the following permitted serum or plasma threshold concentrations that are consistent with administration by a single intravenous injection at least 24 hours before the post time for the race in which the horse is entered:

- Phenylbutazone (or its metabolite oxyphenylbutazone) – 2 micrograms per milliliter;
- Flunixin – 20 nanograms per milliliter;
- Ketoprofen – 2 nanograms per milliliter.

2. The NSAIDs listed in numbered paragraph 10.9(1)*"k"*(1)"1" or any other NSAIDs are prohibited from being administered within the 24 hours before post time for the race in which the horse is entered.

3. The presence of more than one of the three approved NSAIDs, with the exception of phenylbutazone in a concentration below 0.3 micrograms per milliliter, flunixin in a concentration below 3 nanograms per milliliter, or ketoprofen in a concentration below 1 nanogram per milliliter of serum or plasma, or the presence of any unapproved NSAID in the post-race serum or plasma sample is not permitted. The use of all but one of the approved NSAIDs must be discontinued at least 48 hours before the post time for the race in which the horse is entered.

(2) Any horse to which an NSAID has been administered is subject to having a blood sample(s), urine sample(s) or both taken at the direction of the official veterinarian to determine the quantitative NSAID level(s) or the presence of other drugs that may be present in the blood or urine sample(s).

l. NSAIDs in quarter horses.

(1) "Approved NSAIDs" means only phenylbutazone (or its metabolite oxyphenylbutazone), flunixin, or ketaprofen. "Approved NSAIDs" does not include any other substance.

(2) The use of one of three approved NSAIDs is permitted under the circumstances set forth in this paragraph. The presence of more than one of the three approved NSAIDs, with the exception of phenylbutazone in a concentration below 1 microgram per milliliter of serum or plasma, is not permitted. The presence of any unapproved NSAID in the post-race serum or plasma sample is not permitted.

(3) The permissible level for approved NSAIDs cannot exceed concentrations that are consistent with administration by a single intravenous injection at least 48 hours before the post time for the race in which the horse is entered: 0.3 micrograms of phenylbutazone or oxyphenylbutazone per milliliter of serum or plasma; 5 nanograms of flunixin per milliliter of serum or plasma; or 2 nanograms of ketoprofen per milliliter of serum or plasma.

(4) Approved NSAIDs, or any other NSAIDs, cannot be administered within the 48 hours before post time for the race in which the horse is entered. Use of all but one approved NSAID must be discontinued at least 48 hours before the post time for the race in which the horse is entered.

10.9(2) *Sample collection of bodily substances.*

a. Under the supervision of the commission veterinarian, urine, blood, hair, and other bodily substances may be taken and tested from any horse that the stewards, commission veterinarian, or commission's representatives may designate. The samples will be collected by the commission veterinarian or other person or persons the commission may designate. Each sample is marked or numbered and bears information essential to its proper analysis, but the identity of the horse from which the sample was taken or the identity of its owners or trainer is not revealed to the official chemist or the staff of the chemist. The container of each sample is sealed as soon as the sample is placed therein.

b. No unauthorized person may be admitted at any time to the building or the area utilized for the purpose of collecting the required samples or the area designated for the retention of horses pending the obtaining of samples.

c. During the taking of samples from a horse, the owner, responsible trainer, or a representative designated by the owner or trainer may be present and witness the taking of the sample and so signify in writing. Failure to be present and witness the collection of the samples constitutes a waiver by the owner, trainer, or representative of any objections to the source and documentation of the sample.

d. The commission veterinarian, the board of stewards, agents of the division of criminal investigation, or a commission representative may take samples of any medicine or other materials suspected of containing improper medication, drugs, or other substance that could affect the racing condition of a horse in a race that may be found in barns or elsewhere on facility premises or in the possession of any person connected with racing, and the samples will be delivered to the official chemist for analysis.

e. Nothing in these rules is intended to prevent:

(1) Any horse in any race from being subjected by the order of a steward or the commission veterinarian to tests of bodily substances for the purpose of determining the presence of any foreign substance.

(2) The state steward or the commission veterinarian from authorizing the splitting of any sample.

(3) The commission or commission veterinarian from requiring bodily substances to be stored in a frozen state for future analysis.

f. Before leaving the racing surface, the trainer will ascertain the testing status of the horse under the trainer's care from the commission veterinarian or designated detention barn representative.

10.9(3) *Chemists or laboratory.*

a. Tests are to be under the supervision of the commission, which will employ one or more chemists or contract with one or more qualified chemical laboratories to determine by chemical testing

and analysis of bodily substances whether a foreign substance, medication, drug or metabolic derivative thereof is present.

b. All bodily substance samples taken by or under direction of the commission veterinarian or commission representative will be delivered to the laboratory of the official chemist for analysis.

c. The commission chemist is responsible for safeguarding and testing each sample delivered to the laboratory by the commission veterinarian.

d. The commission chemist conducts individual tests on each sample, screening them for prohibited substances, and conducting other tests to detect and identify any suspected prohibited substance or metabolic derivative thereof with specificity. Pooling of samples is permitted only with the written approval of the administrator.

e. Upon the finding of a test negative for prohibited substances, the remaining portions of the sample may be discarded. Upon the finding of a test suspicious or positive for prohibited substances, the test will be reconfirmed and the remaining portion, if available, of the sample will be preserved and protected for one year following close of meet.

f. The commission chemist submits a written report to the commission as to each sample tested, indicating by sample tag identification number, whether the sample was tested negative or positive for prohibited substances. The commission chemist will not report test findings to any person other than commission representatives designated by the administrator.

g. If the commission chemist finds a sample suspicious for a prohibited medication, additional time for test analysis and confirmation may be requested.

h. In reporting to the commission representative a finding of a test positive for a prohibited substance, the commission chemist will present documentary or demonstrative evidence acceptable in the scientific community and admissible in court in support of the professional opinion as to the positive finding.

i. No action will be taken by the state steward until an official report signed by the chemist properly identifying the medication, drug, or other substance as well as the horse from which the sample was taken has been received.

j. The cost of the testing and analysis will be paid by the commission to the official chemist. The commission will then be reimbursed by each facility on a per-sample basis so that each facility bears only its proportion of the total cost of testing and analysis. The commission may first receive payment from funds provided in Iowa Code chapter 99D, if available.

10.9(4) *Practicing veterinarian.*

a. Prohibited acts.

(1) Ownership. A licensed veterinarian practicing at any meeting cannot hold any ownership, directly or indirectly, in any racing animal racing during the meeting.

(2) Wagering. Veterinarians licensed by the commission as veterinarians cannot place any wager of money or other thing of value directly or indirectly on the outcome of any race conducted at the meeting at which the veterinarian is furnishing professional service.

(3) Furnishing injectable materials. No veterinarian shall within the facility premises furnish, sell, or loan any hypodermic syringe, needle, or other injection device, or any drug, narcotic, or prohibited substance to any other person unless with written permission of the stewards.

(4) Contact with entered horse within 24 hours before post time. Practicing veterinarians cannot have contact with an entered horse within 24 hours before the scheduled post time of the race in which the horse is scheduled to compete unless (1) approved by the state veterinarian or (2) in the case of emergency. In case of an emergency, the state veterinarian must be notified prior to entering the stall. A documented attempt to contact the state veterinarian prior to entering the stall complies with the notification requirements of this rule. Any unauthorized contact may result in the horse being scratched from the race in which it was scheduled to compete and may result in further disciplinary action by the stewards.

b. Syringes, hypodermic needles, and infusion tubes. The use of other than single-use disposable syringes and infusion tubes on facility premises is prohibited. Whenever a veterinarian has used a

hypodermic needle or syringe, the veterinarian must destroy the needle and syringe and remove the needle and syringe from the facility premises.

c. Required reports. Practicing veterinarians must submit reports to the commission veterinarian as follows:

(1) Medication and other substance reports in accordance with Iowa Code section 99D.25(10), including the racing animal; trainer; procedure; medication or other substance; dosage or quantity; route of administration; and the date and time administered, dispensed, or prescribed.

(2) A copy of an updated logbook of procedures and other professional services or treatments, as described in Iowa Code section 99D.25(10), within 24 hours after the procedure, professional service, or treatment is provided or completed.

(3) Immediately upon discovering or diagnosing any illness presenting unusual or unknown symptoms in a racing animal entrusted to the veterinarian's care.

(4) Immediately upon euthanizing any horse on facility premises.

d. Additional scope-of-practice parameters. Practicing veterinarians are subject to the professional scope and standards of practice established by the state of Iowa veterinary regulatory authority. In addition, practicing veterinarians are subject to the following scope-of-practice parameters while caring for and treating racing animals:

(1) Practicing veterinarians may have employees licensed as veterinary assistants working under their direct supervision. Activities of these employees cannot include direct treatment or diagnosis of any animal. The practicing veterinarian must be present if a veterinary assistant is to have access to injection devices or injectables. The practicing veterinarian assumes all responsibility for a veterinary assistant. A veterinary assistant cannot engage in activities that a practicing veterinarian is prohibited from engaging in, including performing other work that would put the assistant in contact with an entered horse within 24 hours before post time.

(2) Equine dentistry is considered a function of veterinary practice by the Iowa veterinary practice Act. Any dental procedures performed at the facility must be performed by a licensed veterinarian or a licensed veterinary assistant.

These rules are intended to implement Iowa Code chapter 99D.

REVENUE DEPARTMENT

Notice of Electric and Natural Gas Delivery Tax Rates and Municipal Electric and Natural Gas Transfer Replacement Tax Rates for Each Competitive Service Area

Pursuant to the authority of Iowa Code sections 437A.4 and 437A.5, the Director of Revenue hereby gives notice of the electric delivery tax rate, the municipal electric transfer replacement tax rate, the natural gas delivery tax rate, and the municipal natural gas transfer replacement tax rate for each competitive service area in the state. These rates will be used in conjunction with the number of kilowatt hours of electricity and the number of therms of natural gas delivered to consumers in calendar year 2025 by each taxpayer to determine the tax due for each taxpayer in the 2026-2027 fiscal year.

2025 ELECTRIC DELIVERY TAX RATES BY SERVICE AREA

CO. #	MUNICIPAL ELECTRICS	DELIVERY TAX RATE
3226	Akron Municipal Utilities	0.00005016
3201	Algona Municipal Utilities	0.00023323
3205	Alta Municipal Power Plant	0.00008290
3069	Alta Vista Municipal Utilities	0.00000000

CO. #	MUNICIPAL ELECTRICS	DELIVERY TAX RATE
3070	Alton Municipal Light & Power	0.00000000
3207	Ames Municipal Electric System	0.00000094
3071	Anita Municipal Utilities	0.00000000
3227	Anthon Municipal Electric Utility	0.00010389
3209	Atlantic Municipal Utilities	0.00015621
3073	Auburn Municipal Utility	0.00000000
3074	Aurelia Mun. Electric Utility	0.00007365
3211	Bancroft Municipal Utilities	0.00090449
3213	Bellevue Municipal Utilities	0.00007880
3228	Bigelow Municipal Electric Utility	0.00342748
3229	Bloomfield Municipal Electric Utility	0.00003607
3075	Breda Mun. Electric System	0.00000000
3076	Brooklyn Municipal Utilities	0.00132929
3216	Buffalo Municipal Electric System	0.00000225
3217	Burt Municipal Electric Utility	0.00000203
3077	Callender Electric	0.00000000
3078	Carlisle Municipal Utilities	0.00000000
3079	Cascade Municipal Utilities	0.00139918
3221	Cedar Falls Municipal Elec. Utility	0.00022360
3068	City of Afton	0.00000000
3072	City of Aplington	0.00000000
3082	City of Dike	0.00000000
3088	City of Estherville	0.00000000
3089	City of Fairbank	0.00000000
3090	City of Farnhamville	0.00000000
3230	City of Fredericksburg	0.00000777
3106	City of Larchwood	0.00000000
3107	City of Lawler	0.00000000
3108	City of Lehigh	0.00000000
3113	City of Marathon	0.00000000
3311	City of Pella	0.00007414
3125	City of Renwick	0.00000000
3129	City of Sergeant Bluff	0.00000000
3139	City of Westfield	0.00000000
3143	City of Woolstock	0.00000000
3236	Coggon Municipal Light Plant	0.00004374
3237	Coon Rapids Municipal Utilities	0.00003650
3242	Corning Municipal Utilities	0.00031761
3080	Corwith Municipal Utilities	0.00000000
3243	Danville Municipal Electric Utility	0.00000384
3081	Dayton Light & Power	0.00000000
3244	Denison Municipal Utilities	0.00001027
3245	Denver Municipal Electric Utility	0.00005928
3083	Durant Municipal Electric Plant	0.00000000
3084	Dysart Municipal Utilities	0.00000000
3085	Earlville Municipal Utilities	0.00137177
3087	Ellsworth Municipal Utilities	0.00000000
3091	Fonda Municipal Electric	0.00000000

CO. #	MUNICIPAL ELECTRICS	DELIVERY TAX RATE
3252	Fontanelle Municipal Utilities	0.00033407
3092	Forest City Municipal Utilities	0.00000000
3231	Glidden Municipal Electric Utility	0.00000214
3093	Gowrie Municipal Utilities	0.00148389
3256	Graettinger Municipal Light Plant	0.00028010
3094	Grafton Municipal Utilities	0.00000000
3258	Grand Junction Municipal Utilities	0.00000500
3095	Greenfield Municipal Utilities	0.00106593
3096	Grundy Center Light & Power	0.00022173
3232	Guttenberg Municipal Electric	0.00002873
3263	Harlan Municipal Utilities	0.00139596
3097	Hartley Municipal Utilities	0.00000000
3098	Hawarden Municipal Utility	0.00000000
3099	Hinton Municipal Electric/Water	0.00007183
3267	Hopkinton Municipal Utilities	0.00000617
3100	Hudson Municipal Utilities	0.00000000
3101	Independence Light & Power	0.00000000
3271	Indianola Municipal Utilities	0.00000742
3102	Keosauqua Light & Power	0.00000000
3103	Kimballton Municipal Utilities	0.00000000
3104	Lake Mills Municipal Utilities	0.00000000
3105	Lake Park Municipal Utilities	0.00000000
3233	Lake View Municipal Utilities	0.00015764
3274	Lamoni Municipal Utilities	0.00140260
3276	LaPorte City Utilities	0.00000998
3277	Laurens Municipal Utilities	0.00029015
3109	Lenox Mun. Light & Power	0.00052072
3110	Livermore Municipal Utilities	0.00000000
3111	Long Grove Mun. Elec./Water	0.00000000
3282	Manilla Municipal Elec. Utilities	0.00011543
3112	Manning Municipal Electric	0.00009509
3284	Mapleton Municipal Utilities	0.00008732
3285	Maquoketa Municipal Electric	0.00004721
3288	McGregor Municipal Utilities	0.00000776
3291	Milford Municipal Utilities	0.00018034
3114	Montezuma Municipal Light & Power	0.00000000
3115	Mount Pleasant Municipal Utilities	0.00000000
3293	Muscatine Municipal Utilities	0.00009555
3116	Neola Light & Water System	0.00000000
3297	New Hampton Municipal Light Plant	0.00009487
3298	New London Municipal Utility	0.00052973
3304	Ogden Municipal Utilities	0.00006019
3234	Onawa Municipal Utilities	0.00009815
3117	Orange City Municipal Utilities	0.00000000
3118	Orient Municipal Utilities	0.00000000
3307	Osage Municipal Utilities	0.00004946
3309	Panora Municipal Electric Utility	0.00006300
3119	Paton Municipal Utilities	0.00000000

CO. #	MUNICIPAL ELECTRICS	DELIVERY TAX RATE
3120	Paullina Municipal Utilities	0.00000000
3121	Pocahontas Municipal Utilities	0.00000000
3122	Preston Municipal Utilities	0.00000000
3315	Primghar Municipal Light Plant	0.00001643
3123	Readlyn Municipal Utilities	0.00000000
3124	Remsen Municipal Utilities	0.00000000
3318	Rock Rapids Municipal Utilities	0.00000479
3126	Rockford Municipal Light Plant	0.00000000
3127	Sabula Municipal Utilities	0.00000000
3128	Sanborn Municipal Light & Plant	0.00000000
3130	Shelby Municipal Utilities	0.00000000
3131	Sibley Municipal Utilities	0.00000000
3321	Sioux Center Municipal Utilities	0.00000087
3323	Southern Minnesota Mun. Power	0.00000000
3324	Spencer Municipal Utilities	0.00012945
3132	Stanhope Municipal Utilities	0.00000000
3360	Stanton Municipal Utilities	0.00000000
3326	State Center Municipal Light Plant	0.00027766
3327	Story City Municipal Electric Utility	0.00010916
3134	Stratford Municipal Utilities	0.00000000
3135	Strawberry Point Electric Utility	0.00000000
3136	Stuart Municipal Utilities	0.00121418
3328	Sumner Municipal Light Plant	0.00020357
3330	Tipton Municipal Utilities	0.00143611
3332	Traer Municipal Utilities	0.00057746
3337	Villisca Municipal Power Plant	0.00025674
3137	Vinton Municipal Utilities	0.00000000
3138	Wall Lake Municipal Utilities	0.00000000
3338	Waverly Light & Power	0.00078139
3342	Webster City Municipal Utilities	0.00042187
3345	West Bend Municipal Power Plant	0.00075045
3346	West Liberty Municipal Electric Util.	0.00000626
3347	West Point Municipal Utility System	0.00167501
3140	Whittemore Municipal Utilities	0.00000000
3141	Wilton Municipal Light & Power	0.00000000
3351	Winterset Municipal Utilities	0.00133211
3142	Woodbine Municipal Utilities	0.00000000

CO. #	IOUs — ELECTRIC	DELIVERY TAX RATE
7206	Amana Society Service Co.	0.00075832
7248	Eldridge Electric & Water Utilities	0.00054889
7354	Geneseo Municipal Utilities	0.00000000
7270	IES Utilities	0.00237888
7272	Interstate Power	0.00103630
7289	MidAmerican Energy	0.00242982
7296	Nebraska Public Power District	0.00000000

CO. #	IOUs — ELECTRIC	DELIVERY TAX RATE
7302	Northwestern Corporation	0.00000000
7305	Omaha Public Power District	0.00123835
7334	Union Electric	0.00000000

CO. #	RECs	DELIVERY TAX RATE
4319	Access Energy Coop	0.00052554
4203	Allamakee Clayton Electric Coop	0.00093586
4208	Atchison-Holt Electric Coop	0.00085628
4214	Boone Valley Electric Coop	0.00089047
4218	Butler County REC	0.00062535
4219	Calhoun County Electric Coop	0.00109354
4220	Cass Electric Coop	0.00004961
4224	Central Iowa Power Coop	0.00000000
4225	Chariton Valley Electric Coop	0.00102029
4235	Clarke Electric Coop	0.00234795
4287	Consumers Energy	0.00111082
4240	Corn Belt Power Coop	0.00000000
4246	East-Central Iowa REC	0.00193233
4247	Eastern Iowa Light & Power	0.00068026
4250	Farmers Electric Coop - Greenfield	0.00258206
4249	Farmers Electric Coop - Kalona	0.00047680
4251	Federated Rural Electric	0.00035393
4253	Franklin Rural Electric Coop	0.00071413
4254	Freeborn-Mower Cooperative	0.00225371
4255	Glidden Rural Electric Coop	0.00072443
4259	Grundy County REC	0.00063081
4260	Grundy Electric Cooperative	0.00052083
4261	Guthrie County REC	0.00121604
4262	Hancock Co. REC	0.00097751
4265	Harrison County REC	0.00059147
4266	Hawkeye REC	0.00048416
4223	Heartland Power Coop	0.00031479
4268	Humboldt County REC	0.00096090
4273	Iowa Lakes Electric Coop	0.00068661
4279	Linn County REC	0.00133993
4280	Lyon Rural Electric Coop	0.00046282
4286	Maquoketa Valley Electric Coop	0.00221262
4290	Midland Power Cooperative	0.00094536
4299	Nishnabotna Valley REC	0.00049174
4300	North West Rural Electric Coop	0.00033128
4301	Northwest Iowa Power Coop	0.00000000
4308	Osceola Electric Coop	0.00020752
4310	Pella Cooperative Electric	0.00182080
4313	Pleasant Hill Community Line	0.00028001
4316	Rideta Electric Coop	0.00263826
4320	Sac County Rural Electric Coop	0.00064621

CO. #	RECs	DELIVERY TAX RATE
4322	Southern Iowa Electric Coop	0.00134566
4379	Southwest Iowa Service Coop	0.00305638
4329	T.I.P. Rural Electric Coop	0.00203782
4333	Tri County Electric Coop	0.00077970
4336	United Electric Coop	0.00123613
4348	Western Iowa Power Coop	0.00112627
4352	Woodbury County REC	0.00073287
4353	Wright County REC	0.00040495

2025 NATURAL GAS DELIVERY TAX RATES BY SERVICE AREA

CO. #	MUNICIPAL GAS	DELIVERY TAX RATE
5021	Bedford Municipal Gas	0.00000000
5215	Brighton Gas	0.00742628
5023	Brooklyn Municipal Gas	0.00000000
5024	Cascade Municipal Gas	0.00000000
5025	Cedar Falls Municipal Gas	0.00000000
5022	City of Bloomfield	0.00000000
5026	City of Clearfield	0.00000000
5028	City of Everly	0.00000000
5029	City of Fairbank	0.00000000
5238	Coon Rapids Municipal Gas	0.00004778
5241	Corning Municipal Gas	0.00000765
5027	Emmetsburg Municipal Gas	0.00000000
5030	Gilmore City Municipal Gas	0.00000000
5031	Graettinger Municipal Gas	0.00000000
5032	Guthrie Center Municipal Gas	0.00000000
5033	Harlan Municipal Gas	0.00000000
5034	Hartley Municipal Gas	0.00000000
5035	Hawarden Municipal Gas	0.00000000
5036	Lake Park Municipal Gas	0.00000000
5275	Lamoni Municipal Gas	0.00086814
5037	Lenox Municipal Gas	0.00000000
5038	Lineville City Natural Gas	0.00000000
5039	Lorimor Municipal Gas	0.00000000
5281	Manilla Municipal Gas	0.00523888
5283	Manning Municipal Gas	0.00011037
5040	Montezuma Natural Gas	0.00000000
5041	Morning Sun Municipal Gas	0.00000000
5042	Moulton Municipal Gas	0.00000000
5306	Osage Municipal Gas	0.00002474
5043	Prescott Municipal Gas	0.00000000
5044	Preston Municipal Gas	0.00000000
5055	Remsen Municipal Gas	0.00000000
5317	Rock Rapids Municipal Gas	0.00013139
5056	Rolfe Municipal Gas	0.00000000
5057	Sabula Municipal Gas	0.00000000

CO. #	MUNICIPAL GAS	DELIVERY TAX RATE
5058	Sac City Municipal Gas	0.00000000
5059	Sanborn Municipal Gas	0.00000000
5060	Sioux Center Municipal Gas	0.00000000
5061	Tipton Municipal Gas	0.00000000
5063	Waukee Municipal Gas	0.00000000
5340	Wayland Municipal Gas	0.00020700
5064	Wellman Municipal Gas	0.00000000
5344	West Bend Municipal Gas	0.00003088
5065	Whittemore Municipal Gas	0.00000000
5349	Winfield Municipal Gas	0.00098466
5066	Woodbine Gas	0.00000000

CO. #	IOUs — GAS	DELIVERY TAX RATE
5204	Allerton Gas	0.03107436
5270	IES Utilities-Gas	0.00677129
5272	Interstate Power-Gas	0.00250175
5289	MidAmerican Energy-Gas	0.00641133
5312	Peoples Natural Gas	0.00640722
5335	United Cities Gas	0.00241563

2025 MUNICIPAL ELECTRIC TRANSFER REPLACEMENT TAX RATES

CO. #	COMPANY	REPLACEMENT TAX RATE
3226	Akron Municipal Utilities	0.01778990
3201	Algona Municipal Utilities	0.00354324
3205	Alta Municipal Power Plant	0.00313454
3069	Alta Vista Municipal Utilities	*
3070	Alton Municipal Light & Power	0.00216458
3207	Ames Municipal Electric System	0.00408557
3071	Anita Municipal Utilities	0.00437315
3227	Anthon Municipal Electric Utility	0.00000000
3209	Atlantic Municipal Utilities	0.00218025
3073	Auburn Municipal Utility	0.00590978
3074	Aurelia Municipal Electric Utility	0.00126779
3211	Bancroft Municipal Utilities	*
3213	Bellevue Municipal Utilities	0.01846030
3228	Bigelow Municipal Utilities	*
3229	Bloomfield Municipal Electric Utility	*
3075	Breda Municipal Electric System	0.00000000
3076	Brooklyn Municipal Utilities	*
3216	Buffalo Municipal Electric System	*
3217	Burt Municipal Electric Utility	*
3077	Callender Electric	*
3078	Carlisle Municipal Utilities	*
3079	Cascade Municipal Utilities	0.00000000

CO. #	COMPANY	REPLACEMENT TAX RATE
3221	Cedar Falls Mun. Electric Utility	*
3068	City of Afton	0.00026346
3072	City of Aplington	*
3082	City of Dike	*
3088	City of Estherville	0.02292250
3089	City of Fairbank	*
3090	City of Farnhamville	0.00000000
3230	City of Fredericksburg	*
3106	City of Larchwood	*
3107	City of Lawler	*
3108	City of Lehigh	*
3113	City of Marathon	*
3311	City of Pella	0.00479499
3125	City of Renwick	0.00000000
3129	City of Sergeant Bluff	0.00183996
3139	City of Westfield	0.00000000
3143	City of Woolstock	*
3236	Coggon Municipal Light Plant	0.00000000
3237	Coon Rapids Municipal Utilities	0.00033922
3242	Corning Municipal Utilities	0.00000000
3080	Corwith Municipal Utilities	0.01411610
3243	Danville Municipal Electric Utility	*
3081	Dayton Light & Power	0.00206597
3244	Denison Municipal Utilities	0.00209677
3245	Denver Municipal Electric Utility	0.00000000
3083	Durant Municipal Electric Plant	*
3084	Dysart Municipal Utilities	0.03358500
3085	Earlville Municipal Utilities	*
3086	Eldridge Electric & Water Utility	0.00000000
3087	Ellsworth Municipal Utilities	*
3091	Fonda Municipal Electric	*
3252	Fontanelle Municipal Utilities	0.00000000
3092	Forest City Municipal Utilities	*
3231	Glidden Municipal Electric Utility	0.00681622
3093	Gowrie Municipal Utilities	*
3256	Graettinger Municipal Light Plant	0.00248162
3094	Grafton Municipal Utilities	0.03289280
3258	Grand Junction Municipal Utilities	0.00272447
3095	Greenfield Municipal Utilities	*
3096	Grundy Center Light & Power	*
3232	Guttenberg Municipal Electric	0.01104610
3263	Harlan Municipal Utilities	*
3097	Hartley Municipal Utilities	0.02827340
3098	Hawarden Municipal Utility	*
3099	Hinton Municipal Electric/Water	*
3267	Hopkinton Municipal Utilities	0.00000000
3100	Hudson Municipal Utilities	*
3101	Independence Light & Power	0.00223150

CO. #	COMPANY	REPLACEMENT TAX RATE
3271	Indianola Municipal Utilities	0.00680371
3102	Keosauqua Light & Power	0.00000000
3103	Kimballton Municipal Utilities	*
3104	Lake Mills Municipal Utilities	0.00825034
3105	Lake Park Municipal Utilities	*
3233	Lake View Municipal Utilities	0.01149940
3274	Lamoni Municipal Utilities	0.00263275
3276	LaPorte City Utilities	0.00232219
3277	Laurens Municipal Utilities	0.00374958
3109	Lenox Municipal Light & Power	0.00000000
3110	Livermore Municipal Utilities	0.00516090
3111	Long Grove Mun. Elec./Water	0.00000000
3282	Manilla Municipal Elec. Utilities	*
3112	Manning Municipal Electric	*
3284	Mapleton Municipal Utilities	0.00481856
3285	Maquoketa Municipal Electric	0.00298441
3288	McGregor Municipal Utilities	0.00192898
3291	Milford Municipal Utilities	0.00000000
3381	Montezuma Municipal Light & Power	*
3115	Mount Pleasant Municipal Utilities	0.00158298
3293	Muscatine Municipal Utilities	0.00000000
3116	Neola Light & Water System	*
3297	New Hampton Municipal Light Plant	0.00313240
3298	New London Municipal Utility	0.00548533
3304	Ogden Municipal Utilities	0.00264854
3234	Onawa Municipal Utilities	0.00487659
3117	Orange City Municipal Utilities	*
3118	Orient Municipal Utilities	*
3307	Osage Municipal Utilities	0.00291144
3309	Panora Municipal Electric Utility	*
3119	Paton Municipal Utilities	0.00000000
3120	Paullina Municipal Utilities	*
3121	Pocahontas Municipal Utilities	*
3122	Preston Municipal Utilities	*
3315	Primghar Municipal Light Plant	0.00000000
3123	Readlyn Municipal Utilities	*
3124	Remsen Municipal Utilities	*
3318	Rock Rapids Municipal Utilities	*
3126	Rockford Municipal Light Plant	*
3127	Sabula Municipal Utilities	0.00123236
3128	Sanborn Municipal Light Plant	*
3130	Shelby Municipal Utilities	0.00000000
3131	Sibley Municipal Utilities	*
3321	Sioux Center Municipal Utilities	0.00409778
3324	Spencer Municipal Utilities	0.00498654
3132	Stanhope Municipal Utilities	*
3360	Stanton Municipal Utilities	0.00520526
3326	State Center Municipal Light Plant	0.00479342

CO. #	COMPANY	REPLACEMENT TAX RATE
3327	Story City Municipal Electric Utility	0.00000000
3134	Stratford Municipal Utilities	0.01981560
3135	Strawberry Point Electric Utility	*
3136	Stuart Municipal Utilities	0.00413617
3328	Sumner Municipal Light Plant	0.00214318
3330	Tipton Municipal Utilities	0.02437850
3332	Traer Municipal Utilities	*
3337	Villisca Municipal Power Plant	*
3137	Vinton Municipal Utilities	0.00229539
3138	Wall Lake Municipal Utilities	*
3338	Waverly Utilities	0.00613623
3342	Webster City Municipal Utilities	0.00748362
3345	West Bend Municipal Power Plant	0.00203767
3346	West Liberty Municipal Electric Util.	*
3347	West Point Municipal Utility System	*
3140	Whittemore Municipal Utilities	*
3141	Wilton Municipal Light & Power	0.00000000
3351	Winterset Municipal Utilities	*
3142	Woodbine Municipal Utilities	0.00261897
3143	Woolstock Municipal Utilities	*

* No rate provided to the Department by the Municipal

2025 MUNICIPAL NATURAL GAS TRANSFER REPLACEMENT TAX RATES

CO. #	COMPANY	REPLACEMENT TAX RATE
5401	Alton Municipal Gas	0.00000000
5021	Bedford Municipal Gas	0.79196300
5215	Brighton Gas	*
5023	Brooklyn Municipal Gas	*
5024	Cascade Municipal Gas	0.00000000
5025	Cedar Falls Municipal Gas	*
5022	City of Bloomfield	*
5026	City of Clearfield	*
5028	City of Everly	*
5029	City of Fairbank	*
5238	Coon Rapids Municipal Gas	0.00292776
5241	Corning Municipal Gas	0.00000000
5027	Emmetsburg Municipal Gas	*
5030	Gilmore City Municipal Gas	*
5031	Graettinger Municipal Gas	0.05603654
5032	Guthrie Center Municipal Gas	*
5033	Harlan Municipal Gas	*
5034	Hartley Municipal Gas	0.10941300
5035	Hawarden Municipal Gas	*
5036	Lake Park Municipal Gas	*
5275	Lamoni Municipal Gas	0.02706500
5037	Lenox Municipal Gas	*

CO. #	COMPANY	REPLACEMENT TAX RATE
5038	Lineville City Natural Gas	*
5039	Lorimor Municipal Gas	*
5281	Manilla Municipal Gas	*
5283	Manning Municipal Gas	*
5402	Mapleton Municipal Gas	0.00000000
5040	Montezuma Natural Gas	*
5041	Morning Sun Municipal Gas	*
5042	Moulton Municipal Gas	*
5369	Orange City Municipal Gas	*
5306	Osage Municipal Gas	0.00549862
5043	Prescott Municipal Gas	*
5044	Preston Municipal Gas	*
5055	Remsen Municipal Gas	*
5317	Rock Rapids Municipal Gas	*
5056	Rolfe Municipal Gas	0.00000000
5057	Sabula Municipal Gas	1.78774000
5058	Sac City Municipal Gas	*
5059	Sanborn Municipal Gas	*
5060	Sioux Center Municipal Gas	0.00869924
5061	Tipton Municipal Gas	0.08468040
5067	Wall Lake Municipal Gas	*
5063	Waukee Municipal Gas	*
5340	Wayland Municipal Gas	0.03202770
5064	Wellman Municipal Gas	*
5344	West Bend Municipal Gas	0.04454730
5065	Whittemore Municipal Gas	*
5349	Winfield Municipal Gas	0.00000000
5066	Woodbine Gas	*

* No rate provided to the Department by the Municipal

Notice of Rate-Regulated Water Utilities Delivery Tax Rate

Pursuant to the authority of Iowa Code section 437B.3, the Director of Revenue hereby gives notice of the rate-regulated water utility delivery tax rate. This rate will be used in conjunction with the total gallons of water delivered to consumers in calendar year 2025 by each taxpayer to determine replacement taxes payable in the 2026-2027 fiscal year.

2025 RATE-REGULATED WATER UTILITIES DELIVERY TAX RATE BY SERVICE AREA

CO. #	RATE-REGULATED WATER	DELIVERY TAX RATE
6020	Iowa American Water	0.00057387

TREASURER OF STATE

Notice—Public Funds Interest Rates

In compliance with Iowa Code chapter 74A and section 12C.6, the following interest rates of interest for public obligations and special assessments have been established. The usury rate for December is 6.00%.

INTEREST RATES FOR PUBLIC OBLIGATIONS AND ASSESSMENTS

74A.2 Unpaid Warrants	Maximum 6.0%
74A.4 Special Assessments	Maximum 9.0%

RECOMMENDED Rates for Public Obligations (74A.3) and School District Warrants (74A.7). A rate equal to 75% of the Federal Reserve monthly published indices for U.S. Government securities of comparable maturities. All Financial Institutions as defined by Iowa Code section 12C.1 are eligible for public fund deposits as defined by Iowa Code section 12C.6A.

The rate of interest has been determined to be the minimum interest rate that shall be paid on public funds deposited in approved financial institutions. To be eligible to accept deposits of public funds of the state of Iowa, a financial institution shall demonstrate a commitment to serve the needs of the local community in which it is chartered to do business. These needs include credit services as well as deposit services. All such financial institutions are required to provide the committee with a written description of their commitment to provide credit services in the community. This statement is available for examination by citizens.

New official state interest rates, effective December 9, 2025, setting the minimums that may be paid by Iowa depositories on public funds are listed below.

TIME DEPOSITS

7-31 days	Minimum .05%
32-89 days	Minimum .05%
90-179 days	Minimum 1.70%
180-364 days	Minimum 1.60%
One year to 397 days	Minimum 1.75%
More than 397 days	Minimum 1.80%

These are minimum rates only. All time deposits are four-tenths of a percent below average rates. Public body treasurers and their depositories may negotiate a higher rate according to money market rates and conditions.

Inquiries may be sent to Roby Smith, Treasurer of State, State Capitol, Des Moines, Iowa 50319.

USURY

In accordance with the provisions of Iowa Code section 535.2(3)“a,” the Superintendent of Banking has determined that the maximum lawful rate of interest shall be:

January 1, 2025 — January 31, 2025	6.25%
February 1, 2025 — February 28, 2025	6.50%
March 1, 2025 — March 31, 2025	6.75%
April 1, 2025 — April 30, 2025	6.50%
May 1, 2025 — May 31, 2025	6.25%
June 1, 2025 — June 30, 2025	6.25%
July 1, 2025 — July 31, 2025	6.50%
August 1, 2025 — August 31, 2025	6.50%
September 1, 2025 — September 30, 2025	6.50%

October 1, 2025 — October 31, 2025	6.25%
November 1, 2025 — November 30, 2025	6.00%
December 1, 2025 — December 31, 2025	6.00%
January 1, 2026 — January 31, 2026	6.00%

ARC 9857C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Adopted and Filed

Rulemaking related to length of service awards program grant fund

The Economic Development Authority hereby adopts new Chapter 21, "Length of Service Awards Program Grant Fund," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 15.106A and 2025 Iowa Acts, House File 1002.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2025 Iowa Acts, House File 1002.

Purpose and Summary

Pursuant to Iowa Code section 100B.52 as enacted by 2025 Iowa Acts, House File 1002, the Authority has adopted a new Chapter 21. The chapter describes the policies and procedures applicable to the Length of Service Awards Program Grant Fund. The program provides awards to municipalities that have established length of service awards programs for volunteer fire fighters, volunteer emergency medical care providers, and reserve peace officers. The chapter will set forth eligibility requirements, application procedures, and review processes for the program.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 15, 2025, as **ARC 9611C**. No public comments were received.

Changes from the Notice have been made to clarify that the resolution of a municipality's governing body establishing a length of service awards program should confirm the municipality's program meets the requirements of Iowa Code section 100B.51 and Title 26 of the U.S. Code (26 U.S.C. Section 457).

Adoption of Rulemaking

This rulemaking was adopted by the Authority Board on November 21, 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.

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 28, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 261—Chapter 21:

CHAPTER 21
LENGTH OF SERVICE AWARDS PROGRAM GRANT FUND

261—21.1(15) Purpose. The length of service awards program grant fund is created pursuant to and for the purposes stated under Iowa Code section 100B.52 as enacted by 2025 Iowa Acts, House File 1002.

261—21.2(15) Definitions.

"Applicant" means an eligible municipality that is applying for a grant.

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

"Emergency medical care provider" means the same as defined in Iowa Code section 147A.1.

"Grant" means financial assistance provided by the authority from the length of service awards program grant fund established pursuant to Iowa Code section 100B.52 as enacted by 2025 Iowa Acts, House File 1002, and administered pursuant to this chapter.

"Municipality" means the same as defined in Iowa Code section 100B.21.

"Participant" means a volunteer emergency medical care provider, reserve peace officer or volunteer firefighter receiving funds under a program.

"Program" means a length of service award program created by an applicant that meets the requirements set forth in Iowa Code section 100B.51 as enacted by 2025 Iowa Acts, House File 1002, and Title 26 of the U.S. Code (26 U.S.C. Section 457(e)(11)).

"Recipient" means a municipality that has been awarded a grant.

"Reserve peace officer" means the same as defined in Iowa Code section 80D.1A.

"Volunteer" means the same as defined in Iowa Code section 100B.51 as enacted by 2025 Iowa Acts, House File 1002.

"Volunteer firefighter" means the same as defined in Iowa Code section 85.61.

261—21.3(15) Eligible applicants. To be eligible for a grant, an applicant must be a municipality that has:

21.3(1) Created a program by resolution or ordinance from the municipality's governing body for volunteer emergency medical care providers, volunteer firefighters and reserve peace officers and confirmed by such resolution or ordinance that the program meets the requirements set forth in Iowa Code section 100B.51 as enacted by 2025 Iowa Acts, House File 1002, and Title 26 of the U.S. Code (26 U.S.C. Section 457).

21.3(2) Created a dedicated account for the sole purpose of funding and managing its program.

261—21.4(15) Application procedures. An applicant will be required to:

21.4(1) Electronically file the applicant's grant application in the form and content prescribed by the authority.

21.4(2) Provide the authority with a certified copy of a resolution or ordinance from the applicant's governing body creating a qualified program.

21.4(3) Provide the authority with a roster of participants in the applicant's program. Volunteer emergency medical care providers, reserve peace officers and volunteer firefighters shall only be included in a roster for one program per application cycle.

261—21.5(15) Application review process. An application will be reviewed by the authority for funding approval based on an applicant's eligibility and the completeness of the applicant's application. Based on the review process and subject to available funding, the authority may revise the applicant's overall funding request pursuant to Iowa Code section 100B.52 as enacted by 2025 Iowa Acts, House File 1002.

261—21.6(15) Matching contributions. A recipient shall meet the match requirements specified in Iowa Code section 100B.52 as enacted by 2025 Iowa Acts, House File 1002.

261—21.7(15) Administration.

21.7(1) The authority will notify a successful applicant in writing of the applicant's approved application for funding and prepare an agreement that reflects the terms of the grant award. The successful applicant must execute and return the agreement to the authority within 45 days of the transmittal of the final agreement from the authority. Failure to do so may result in the authority terminating the award.

21.7(2) Following execution of the final agreement, the authority will disburse the grant funds to the recipient for deposit into the recipient's dedicated program fund.

21.7(3) A recipient shall allow access by the Office of Auditor of State, the authority or the authority's designee to all books, accounts, reports and other records pertaining to the recipient's receipt of a grant, management of and contributions made to the recipient's dedicated program account, and the administration of the recipient's program.

21.7(4) Should the authority find that a recipient is not in compliance with any of the requirements for receiving a grant, the authority may employ any remedies it deems appropriate, including but not limited to the following:

a. Issue a warning letter stating that continued failure to comply with grant requirements within a stated period of time will result in a more serious action.

b. Condition a future award on correcting compliance issues.

c. Require that some or all of the awarded funds be remitted to the authority.

d. Elect not to provide future award funds to the recipient until appropriate actions are taken to ensure compliance.

e. Prohibit a future award of funds.

261—21.8(15) References. All references to the United States Code in this chapter are to the laws as in effect January 28, 2026.

These rules are intended to implement Iowa Code section 100B.52 as enacted by 2025 Iowa Acts, House File 1002.

[Filed 12/1/25, effective 1/28/26]
[Published 12/24/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

ARC 9858C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Adopted and Filed

Rulemaking related to the business incentives for growth (BIG) program

The Economic Development Authority hereby adopts new Chapter 69, "Business Incentives for Growth (BIG) Program," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 15.106A and 2025 Iowa Acts, Senate File 657.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2025 Iowa Acts, Senate File 657.

Purpose and Summary

The Authority has adopted a new Chapter 69 to implement Iowa Code chapter 15, subchapter II, part 33, as enacted by 2025 Iowa Acts, Senate File 657. Chapter 69 describes the policies and procedures applicable to the BIG program. The program will provide incentives to businesses to locate, expand, or modernize an Iowa facility. The program will replace the High Quality Jobs program.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 15, 2025, as **ARC 9608C**. No public comments were received.

Changes from the Notice have been made to clarify requirements regarding water conservation and waste reduction plans as well as inclusion of rent payments as investment.

Adoption of Rulemaking

This rulemaking was adopted by the Authority Board on November 21, 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

Some incentives provided through the program will be based on job retention and creation.

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.

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 28, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 261—Chapter 69:

CHAPTER 69
BUSINESS INCENTIVES FOR GROWTH (BIG) PROGRAM

261—69.1(15) Definitions. For purposes of this chapter, unless the context otherwise requires:

"Agreement" means an agreement entered into pursuant to Iowa Code section 15.506 as enacted by 2025 Iowa Acts, Senate File 657.

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

"Award date" means the date the board approved an application for financial assistance or tax incentives.

"Base employment level" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Benefits" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Board" means the same as defined in Iowa Code section 15.102.

"Business" means a sole proprietorship, partnership, corporation, or other business entity organized for profit under the laws of the state of Iowa or another state, under federal statutes, or under the laws of another country.

"Community" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Contract end date" means the date on which an agreement ends.

"Created job" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Data center business" means the same as defined in Iowa Code section 423.3(95).

"Eligible business" means a business that meets the requirements of Iowa Code section 15.504 as enacted by 2025 Iowa Acts, Senate File 657.

"Financial assistance" means the same as defined in Iowa Code section 15.511 as enacted by 2025 Iowa Acts, Senate File 657.

"Full-time equivalent position" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Laborshed area" means the geographic area surrounding an employment center from which the employment center draws its commuting workers as defined by the department of workforce development.

"Placed in service" means in a condition or state of readiness and availability for a specifically assigned function.

"Program" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Project" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Project completion date" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Qualifying investment" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Qualifying wage threshold" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Retained job" means the same as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657.

"Retention-only project" means a project that involves only retained jobs.

"Tax incentive" means a sales and use tax refund approved pursuant to Iowa Code section 15.507 as enacted by 2025 Iowa Acts, Senate File 657; a qualifying investment tax credit approved pursuant to Iowa Code section 15.508 as enacted by 2025 Iowa Acts, Senate File 657; or a combination of both.

"Total project cost" means the total cost incurred by an eligible business to complete a project, including but not limited to qualifying investment, as identified in an agreement.

261—69.2(15) Eligibility requirements.

69.2(1) *Community approval.* Community approval of the project by ordinance or resolution is required as specified in Iowa Code section 15.504 as enacted by 2025 Iowa Acts, Senate File 657.

69.2(2) *Eligible businesses.*

a. For the purposes of determining whether a business is an eligible business type pursuant to Iowa Code section 15.504(1)*"b"* as enacted by 2025 Iowa Acts, Senate File 657, "retail business" means any business primarily engaged in the business of sale at retail of tangible personal property or taxable services in this state or online. "Sale at retail" means the same as defined in Iowa Code section 423.1(46). A business obligated to collect sales or use tax under Iowa Code chapter 423 may be an ineligible retail business.

b. A service business is not eligible for the program unless a significant proportion of its sales, as determined by the authority, are outside this state.

c. A business shall provide evidence that the business's primary operations are in a qualifying industry pursuant to Iowa Code section 15.504(1)*"b"* 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 15.504(1)*"b"* as enacted by 2025 Iowa Acts, Senate File 657, based on factors including but not limited to sources of revenue and customer base.

d. A business shall demonstrate it is not a data center business that is ineligible for the program pursuant to Iowa Code section 15.504(1)*"b"* as enacted by 2025 Iowa Acts, Senate File 657.

e. A foreign business shall demonstrate that it is not associated with a foreign adversary or foreign adversary entity. For the purposes of this paragraph, the following definitions apply:

(1) "Foreign business" means the same as defined in Iowa Code section 9I.1.

(2) "Foreign adversary" means a foreign government or foreign non-government person as determined in 15 CFR §7.4 or 15 CFR §791.4 at any time on March 4, 2024, and that is listed in 15 CFR §7.4(a) or 15 CFR §791.4(a) at any time from March 4, 2024.

(3) "Foreign adversary entity" means a foreign business subject to the jurisdiction of or organized under the laws of a foreign adversary or a foreign business owned, directed, or controlled by a foreign adversary.

69.2(3) *Relocations and reductions in operations.* The authority will determine whether a business is ineligible due to a relocation or reduction in operations pursuant to Iowa Code section 15.504(1)*"c"* as enacted by 2025 Iowa Acts, Senate File 657. For the purposes of this subrule, "reduction in operations" includes but is not limited to a layoff during the 12 months before an application is submitted to the authority.

69.2(4) *Determination of sufficient benefits.* The business shall offer a sufficient package of benefits to each full-time equivalent position included in the business's base employment level and to each full-time equivalent position at the project location until the contract end date. The benefits package provided shall meet the criteria established by the board. The board will periodically approve such criteria to reflect the most current benefits package typically offered by employers. The criteria established by the board may include but not be limited to premium percentages to be paid by the business, deductible amounts, and other such criteria as determined necessary to the evaluation of benefits offered by a business.

69.2(5) *Violations of law.* The authority will address violations of law as described in Iowa Code section 15.504(1)*"e"* as enacted by 2025 Iowa Acts, Senate File 657.

69.2(6) *Sufficient economic impact.* The business shall demonstrate that the project has a sufficient economic impact as described in Iowa Code section 15.504(2)*"b"* as enacted by 2025 Iowa Acts, Senate File 657.

69.2(7) *Created and retained jobs.* The jobs created or retained by a business shall pay the applicable wages as established in rule 261—69.9(15).

69.2(8) *Applicant's past or current performance.* If an applicant received a prior award or other benefit through any program administered by the authority or any other state agency, the authority and board will consider the applicant's past or current performance under the prior award or benefit.

69.2(9) *Results of due diligence review.* The authority will complete a due diligence review, including but not limited to lien searches, reports of violations, pending or resolved litigation, and other relevant information about the applicant. The authority will determine whether a business is ineligible due to the results of the review.

69.2(10) *Other factors.* The authority shall consider any applicable additional factors pursuant to Iowa Code section 15.504(2) as enacted by 2025 Iowa Acts, Senate File 657, to determine whether a business is an eligible business.

69.2(11) *Ineligible projects.*

a. The following activities are presumed by the authority to lack sufficient economic impact to accomplish the goals of the program and are not eligible for the program pursuant to Iowa Code section 15.504(2)*"b"* as enacted by 2025 Iowa Acts, Senate File 657.

(1) Facility maintenance, and

(2) Replacement or upgrades of equipment occurring in the normal course of business.

b. A project representing solely acquisition of a business as a going concern that does not include creation or retention of jobs and qualifying investment at the acquired business facility is not eligible for the program. A qualified project that occurs following acquisition of a business as a going concern may be eligible for the program.

c. If the qualifying investment for a project includes long-term lease costs, the project is not eligible for the program unless the proposed lease is for a term of at least ten years.

69.2(12) *Project initiation.* An eligible business shall not initiate its project prior to board approval of the business's application for the program unless the business establishes that a delay in initiating the project would result in undue hardship or that extenuating circumstances necessitate initiating the project prior to approval of the business's application. Whether an undue hardship or extenuating circumstance exists will be determined by the authority.

a. Any one of the following may indicate that a project has been initiated:

(1) The start of construction of new or expanded buildings;

(2) The start of rehabilitation of existing buildings;

(3) The purchase or leasing of existing buildings; or

(4) The installation of new machinery and equipment or new computers to be used in the operation of the business's project.

b. The following shall not indicate a project has been initiated:

(1) The purchase of land or signing of an option to purchase land;

(2) Earthmoving or other site development activities not involving actual building construction, expansion or rehabilitation; or

(3) Acquisition of a business as a going concern.

c. Any costs incurred prior to the award date are not eligible qualifying investment expenses.

261—69.3(15) Application process and review.

69.3(1) *Application.* Businesses applying for the program shall utilize a standardized application developed by the authority and submit the application to the authority electronically.

69.3(2) *Community participation.* The application shall include an ordinance or resolution of the community's governing body approving the project. If applicable, the application shall also include documentation of any incentives or assistance to be provided by the community for the project.

69.3(3) *Water conservation and waste reduction plan.*

a. To determine whether a water conservation and waste reduction plan is required pursuant to Iowa Code section 15.505(1)*"b"* as enacted by 2025 Iowa Acts, Senate File 657, the authority will consider the following factors:

(1) The total anticipated water consumption and wastewater discharge for the project.

(2) The total capacity of applicable water provider facilities that will serve the project compared to the total anticipated water consumption for the project.

(3) Any information provided by the applicable water provider or local municipality about its ability or inability to accommodate the anticipated water consumption and wastewater discharge for the project.

(4) Any information provided by the department of natural resources (DNR) about the ability or inability of the applicable water provider to accommodate the anticipated water consumption and wastewater discharge for the project or that demonstrates that the applicant is not in good standing with DNR.

(5) Any other factors relevant to water consumption and wastewater management at the project facility.

b. If required, the water conservation and waste reduction plan required by Iowa Code section 15.505(1)*"b"* as enacted by 2025 Iowa Acts, Senate File 657, shall be submitted to the authority as an attachment to the standardized application developed by the authority. The plan should be developed by an employee or third-party provider with sufficient professional expertise to determine the anticipated water consumption and wastewater discharge for the project. The plan shall describe the impact of the project on the applicable water provider and the community or communities served by the applicable water provider and any measures to be taken by the business to mitigate its water consumption or wastewater discharge.

69.3(4) *Applicability of wage requirements.* The qualifying wage threshold applicable to a project is the threshold in effect on the date the fully completed project application is received by the authority. If such an application is received but not acted upon by the board before the qualifying wage thresholds are updated, the thresholds in effect on the date the application was received will remain in effect for a period of three months after the month the thresholds were updated. Qualifying wage thresholds will be calculated and applied as described in rule 261—69.9(15).

69.3(5) *Job requirements.* If applicable, the created job and retained job requirements applicable to a project, identified as described in rule 261—69.8(15), will be established at the time of application. Job requirements will be based on the base employment level on the date the fully completed project application is received by the authority and the eligible business's job projections and will be utilized to determine the amount of tax incentives and financial assistance.

69.3(6) *Investment requirements.* The investment requirements applicable to a project will be established at the time of application. Investment requirements are based on an eligible business's estimates of total project costs and qualifying investment and will be utilized to determine the amount of tax incentives and financial assistance. For the purposes of determining whether an expenditure is a qualifying investment as defined in Iowa Code section 15.503 as enacted by 2025 Iowa Acts, Senate File 657, the following are considered a capital investment in depreciable assets for use in the operation of an eligible business: machinery and equipment used in the manufacturing process, computer hardware, and furniture and fixtures. The following will not be considered a capital investment in depreciable assets for use in the operation of an eligible business: any other machinery and equipment, racking or shelving, computer software, and research and development.

69.3(7) *Board approval and notice.*

a. Authority staff will review applications to ensure program eligibility requirements are satisfied and the application is complete. Authority staff may request additional information from the business or may use other resources to obtain the needed information. The authority or board may engage outside reviewers to complete technical, financial, or other reviews of applications beyond the expertise of the board and authority staff. Negotiation of the terms of, and the aggregate value of, tax incentives and financial assistance will occur following review of an application by authority staff and will be based on the factors identified in rule 261—69.4(15).

b. Complete and eligible applications and supporting documentation will be submitted to the board for its consideration. The authority shall have sole discretion to determine whether an application is fully completed and the date on which it was fully completed. Authority staff will submit a report to the board

that summarizes the project. The report will include recommendations from authority staff on the terms of, and the aggregate value of, tax incentives and, if applicable, financial assistance based on the factors identified in rule 261—69.4(15) or any other elements of the proposed award. Staff may provide the board additional information or documentation as determined by staff. The board may offer an award that differs from that requested or recommended by authority staff. Meeting eligibility requirements does not guarantee that tax incentives or financial assistance will be offered or provided in the manner sought by the applicant.

c. The due diligence committee of the board established pursuant to 261—Chapter 1 will review applications and make recommendations regarding the size and conditions of awards. The board may accept or reject recommendations from the due diligence committee.

d. If the board approves an award, an applicant will be notified in writing, including any conditions and terms of the approval.

69.3(8) *Application fee.* An applicant for the program shall pay an application fee of one-half of 1 percent of the total amount of tax incentives and financial assistance recommended pursuant to paragraph 69.3(7)*"b,"* not to exceed $10,000, at the time an application is submitted to the board for its consideration. If the application fee has not been paid at the time of the board's approval of an application, the board may condition its approval on payment of the fee, including specifying the date by which the fee must be paid. If the board approves a total amount of tax incentives and financial assistance that is more or less than the amount recommended by authority staff, the fee will be adjusted accordingly. The authority may refund the fee if the award is declined or rescinded within 180 days of approval. If the award is declined or rescinded more than 180 days after approval, the fee will not be refunded.

261—69.4(15) Award amounts and terms.

69.4(1) In negotiating the terms of, and the aggregate value of, tax incentives or financial assistance, the authority will consider a variety of factors, including but not limited to the following.

a. Economic impact. The extent to which an eligible business's proposed project demonstrates economic impact on the state based on the factors identified in Iowa Code section 15.504(2)*"b"* as enacted by 2025 Iowa Acts, Senate File 657.

b. Level of need. The following factors will determine the authority's assessment of need:

(1) Whether the business can raise only a portion of the debt and equity necessary to complete the project. The existence of a gap between the financing required and the committed financing indicates that tax incentives or financial assistance may be needed to fill the gap.

(2) Whether the likely returns of the project are inadequate to motivate a company decision maker to proceed with the project even if sufficient debt or equity can be raised to finance the project.

(3) Whether the business is deciding between an Iowa site and a site in another state for its project and the cost of completing the project at the out-of-state site is demonstrably lower. Such a condition indicates that tax incentives or financial assistance may be needed to equalize the cost differential between the two sites. The authority will attempt to quantify the cost differential between the sites.

c. Quality of the jobs. The extent to which the jobs involved in the project are considered higher quality jobs is based on factors, including but not limited to wages; quality of benefits; requirements for specialized skills, education, or both; whether the jobs or applicable industry are expected to have low turnover of employees; and whether the jobs expose employees to minimal occupational hazards.

d. Created jobs. In addition to the number of created jobs, the authority may consider:

(1) The number of created jobs that meet or exceed the qualifying wage threshold relative to the total number of created jobs.

(2) The number of created jobs relative to an eligible business's base employment level.

(3) The number of created jobs relative to the population and employment levels of the community in which the project is located.

e. Community contributions. Whether and to what extent the community in which the project is located is contributing to the success of the project through incentives or assistance.

69.4(2) Eligible businesses that do not propose to create any jobs, including eligible businesses that propose retention-only projects, will receive lower award amounts compared to amounts awarded to eligible businesses that propose to create jobs. The authority may establish award terms specific to projects that do not propose to create jobs.

69.4(3) Eligible businesses that propose a qualifying investment that includes long-term lease costs must demonstrate sufficient economic impact by proposing to create jobs.

69.4(4) Only projects that demonstrate extensive economic impact will be awarded the maximum amounts of tax incentives allowed pursuant to Iowa Code section 15.505(3)*"a"* as enacted by 2025 Iowa Acts, Senate File 657. Whether the project demonstrates extensive economic impact is within the sole discretion of the board.

69.4(5) In addition to the considerations in subrules 69.4(1) through 69.4(4), award negotiations may be impacted by the available amount of investment tax credits allocated pursuant to Iowa Code section 15.119(2) as amended by 2025 Iowa Acts, Senate File 657, or the amount of financial assistance available pursuant to Iowa Code section 15.111 as enacted by 2025 Iowa Acts, Senate File 657.

261—69.5(15) Tax incentives. The authority may approve a business to receive any combination of applicable tax incentives allowed through the program pursuant to Iowa Code section 15.507 or 15.508 as enacted by 2025 Iowa Acts, Senate File 657. An approved business shall not claim a tax incentive in excess of the amount specified in an agreement.

69.5(1) *Property tax exemption.*

a. The authority will only approve a property tax exemption pursuant to Iowa Code section 15.510 as enacted by 2025 Iowa Acts, Senate File 657, if other tax incentives or financial assistance through the program are also approved.

b. If a community approves an exemption from taxation pursuant to Iowa Code section 15.510 as enacted by 2025 Iowa Acts, Senate File 657, the community shall provide the authority and the local assessor with a copy of the resolution adopted by the community's governing body that indicates the estimated value and duration of the authorized exemption.

69.5(2) *Investment tax credit—treatment of rent.* The annual base rent paid to a third-party developer by an approved business may be considered new investment for the purpose of an investment tax credit approved pursuant to Iowa Code section 15.508 as enacted by 2025 Iowa Acts, Senate File 657. Annual base rent incurred during the term of an agreement may be included as new investment. For the purposes of this subrule, "annual base rent" means the business's annual lease payment minus taxes, insurance and operating or maintenance expenses.

69.5(3) *Investment tax credit—issuance, amortization and claims.* The business must notify the authority that its project has been placed in service and document its total project cost, including its qualifying investment, to receive a tax credit certificate. A business shall not receive a tax credit certificate following the placement of a portion of its project in service unless such portion is approved by the authority at the time of application and specified in the agreement. The five-year amortization of a qualifying investment tax credit issued pursuant to Iowa Code section 15.508 as enacted by 2025 Iowa Acts, Senate File 657, shall begin no earlier than the year the credit is issued. Each amortized portion of the credit shall be claimed in the tax year it becomes available except to the extent an overpayment is credited to the immediately succeeding tax year.

261—69.6(15) Financial assistance. The authority may award financial assistance pursuant to Iowa Code sections 15.111 and 15.511 as enacted by 2025 Iowa Acts, Senate File 657. Awards of financial assistance shall be entirely at the discretion of the board.

261—69.7(15) Agreements and compliance.

69.7(1) *Execution.* Successful applicants will be required to execute an agreement within 180 days of the award date. The time limit for execution may be extended by the authority director for an additional 180 days for good cause shown. Upon expiration of the time limit, including any extensions approved pursuant to this subrule, the board may approve additional extensions or rescind the award.

69.7(2) *Requirements.* An agreement shall meet all requirements of and be administered pursuant to Iowa Code section 15.506 as enacted by 2025 Iowa Acts, Senate File 657.

69.7(3) *Jobs.* If applicable, an agreement will specify the number of jobs the business has pledged to create in addition to the base employment level and the number of retained jobs. An agreement may specify that a business has pledged additional jobs or pledged wage requirements greater than the qualifying wage threshold as a condition to receipt of an award or receipt of a specific amount or form of tax incentives or financial assistance. Job obligations will be established and monitored pursuant to rule 261—69.8(15).

69.7(4) *Investment.* An agreement will describe the project and specify the total project cost and qualifying investment the business proposes to make. The agreement will describe the actions to be taken by the business when its investment is placed in service.

69.7(5) *Project completion date.* An agreement will specify the project completion date and the applicable requirements that must be met by the project completion date.

69.7(6) *Contract end date.*

a. The authority will establish a contract end date based on the date the business is expected to have claimed all tax incentives and satisfied any repayment obligations for financial assistance. The contract end date may be earlier than the date specified in an agreement based on actual claims of tax incentives and satisfaction of any job, investment, or repayment obligations. The agreement will specify the applicable requirements that must be met by the contract end date.

b. The total agreement length will be at least two years.

c. An agreement may be terminated prior to the contract end date by mutual agreement of the parties. The amount of tax incentives or financial assistance available may be reduced as described in the agreement if the agreement is terminated prior to the contract end date.

69.7(7) *Conditions to disbursement.* An agreement will specify the conditions to disbursement of financial assistance or issuance of tax incentives, including but not limited to compliance with the requirements of Iowa Code section 15A.1(3)*"b"* regarding solid and hazardous waste.

69.7(8) *Monitoring and reports.* The authority shall ensure that program recipients comply with agreements. An agreement will specify the reports a program recipient must submit to the authority and due dates for such reports. Reports shall be provided in the form and content acceptable to the authority.

a. Recipients shall report annually to the authority about the status of the project, including but not limited to employment, wages, benefits, project costs, investment, and compliance with the agreement. The authority will use the data it collects in the authority's annual report to the general assembly pursuant to Iowa Code section 15.107B.

b. Recipients shall submit a report to the authority to document that the project investment and job obligations have been completed as proposed and prior to the contract end date to verify compliance with the agreement.

c. On-site or remote monitoring may be conducted during the agreement term as deemed appropriate by the authority.

69.7(9) *Default.* An agreement will specify events of default and the remedies available to the authority.

a. Financial assistance. If the authority determines that a recipient is in default, the authority may seek recovery of all financial assistance funds plus interest; assess penalties; negotiate alternative repayment schedules; initiate, suspend or discontinue collection efforts; and take other appropriate action as the board deems necessary. Negotiated settlements, write-offs or discontinuance of collection efforts are subject to approval by the board. If the authority or board refers defaulted agreements to outside counsel for collection, then the terms of the agreement between the authority and the outside counsel regarding the scope of counsel's authorization to accept settlements shall apply.

b. Tax incentives. If the authority determines that a recipient is in default, the eligible business may be required to repay tax incentives pursuant to Iowa Code section 15.506(1)*"b"* as enacted by 2025 Iowa Acts, Senate File 657. The repayment amount is subject to applicable interest and penalties as determined by the department of revenue. If the business is an entity that has elected pass-through

taxation status for income tax purposes, the department of revenue may undertake collection efforts against members, individuals or shareholders to whom the tax incentives were passed through.

c. Calculation of repayment due or reduction.

(1) Job shortfall. If a business does not meet its job requirements, the repayment amount or reduction of tax incentives or financial assistance shall be the same proportion as the amount of the job shortfall. For example, if the business creates 50 percent of the jobs required, the business shall repay 50 percent of the tax incentives or financial assistance received, or tax incentives or financial assistance will be reduced by 50 percent.

(2) Investment shortfall. If a business does not meet the requirements for total project cost or qualifying investment, the repayment amount or reduction of tax incentives or financial assistance shall be the same proportion as the amount of the shortfall in applicable required investment. For example, if the business meets 75 percent of the amount of required qualifying investment, the business shall repay 25 percent of the amount of the tax incentives or financial assistance received, or tax incentives or financial assistance will be reduced by 25 percent. If a business has a shortfall in both total project cost and qualifying investment, the repayment amount or reduction shall be the same proportion as the greater of the two shortfalls.

(3) Job and investment shortfalls. If a business has a shortfall in both investment and job requirements, the repayment amount or reduction shall be the same proportion as the greater of the two shortfalls. For example, if a business creates 50 percent of the required jobs and meets 75 percent of the required qualifying investment, the business shall be required to repay 50 percent of the amount of the tax incentives or financial assistance received, or tax incentives or financial assistance will be reduced by 50 percent.

(4) Benefits. Notwithstanding any other provision in this subrule, if a business fails to comply with the benefit requirements of the agreement, the business shall be required to repay all of the tax incentives or financial assistance received, or tax incentives or financial assistance will be fully revoked.

(5) Minimum eligibility. Notwithstanding any other provision in this subrule, if a business fails to maintain eligibility for the program, the business shall repay all of the tax incentives or financial assistance received, or tax incentives or financial assistance will be fully revoked.

d. Notice of default. The authority will notify a business of an event of default as described in the agreement. If the community in which the project is located provided a property tax exemption pursuant to Iowa Code section 15.510 as enacted by 2025 Iowa Acts, Senate File 657, the authority will also notify the community of an event of default as described in the agreement.

69.7(10) *Amendments.* Agreement amendments must comply with Iowa Code chapter 15, subchapter II, part 33, as enacted by 2025 Iowa Acts, Senate File 657, and this chapter. Recipients may submit requests for amendments to authority staff.

a. Except as provided in paragraph 69.7(10)*"b,"* no request to amend an agreement may be approved unless it has been reviewed by the due diligence committee established pursuant to 261—Chapter 1, the due diligence committee has recommended approving the request to amend the agreement and the board approves the request to amend the agreement.

b. The board may delegate authority to authority staff to approve nonsubstantive changes to the agreement, including but not limited to the following:

(1) Recipient name, address and similar changes.

(2) Collateral changes that do not materially and substantially impact the authority's security.

(3) Line-item budget changes that do not reduce overall total project costs or qualifying investment.

(4) Loan repayment amounts or due dates that do not extend the final due date of a loan.

(5) Changes to tax credit amortization schedules.

(6) Extension of a project completion date or contract end date of up to 12 months.

261—69.8(15) Job counting.

69.8(1) *Overview.* The authority will count created and retained jobs using a base employment analysis comparing the base employment level to employment on another date. The business's base employment level will be established at the time of application for the program. The number of jobs the

business has pledged to create shall be in addition to the base employment level. Retained jobs may be included in the base employment level as established at the time of approval.

69.8(2) *Base employment level.*

a. Base employment level will include the number of full-time equivalent positions employed at the project location. If the project occurs at more than one physical location, the business's base employment level will include the total number of full-time equivalent positions working at the identified locations. Base employment level may include the business's full-time equivalent positions as identified by the authority that are based in this state but are not based at the project location.

b. If a business receives multiple awards for projects at the same location, including through the program or through the high quality jobs program administered pursuant to Iowa Code chapter 15, subchapter II, part 13, the base employment level will be calculated by using the payroll document from the oldest award that is open. Job obligations from each new award will be added to this base employment level.

c. The authority will collect payroll documents to calculate and verify the base employment level used in each award. Payroll documents must include a name or employee identification number and the hourly rate of pay for all full-time equivalent positions.

d. If the base employment level includes retained jobs, the authority will require a business to verify that a job is at risk. Such verification may include the signed statement of an officer of the business, documentation that the business is actively exploring other sites for the project, or any other information the authority may reasonably require during the application review process to establish that a job is at risk.

69.8(3) *Verification.* Payroll documents will be used to calculate and verify compliance with job obligations. The person who submits the documents must, under penalty of perjury, verify that the information contained in the documents is true and correct.

69.8(4) *Full-time equivalent positions.*

a. Only an individual filling a full-time equivalent position will be considered an employee of the business for the purpose of establishing the base employment level, retained jobs, or created jobs. The authority will not consider "job sharing" or any other means of aggregation or combination of hours worked by more than one natural person in counting jobs. The authority will verify that full-time equivalent positions constitute the employment of one person for:

(1) Eight hours per day for a five-day, 40-hour workweek for 52 weeks per year, including paid holidays, vacations and other paid leave; or

(2) The number of hours or days per week, including paid holidays, vacations and other paid leave, currently established by schedule, custom, or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit, provided that the number of hours per week is at least 32 hours per week for 52 weeks per year, including paid holidays, vacations, and other paid leave.

b. If employees at the facility do not typically work 40 hours per week, the business will be required to provide documentation outlining what the business considers a full-time workweek and how the business's interpretation fits within the norms of its industry standards. Whether to accept this interpretation is within the sole discretion of the authority.

69.8(5) *Contract employees.* A business's leased or contract employee may be included in the base employment level as a created job or as a retained job only if the following requirements are met:

a. The business receiving the tax incentives or financial assistance has a legally binding contract with a third-party provider to provide the leased or contract employee.

b. The contract between the third-party provider and the business specifically requires the third-party provider to pay the wages and benefits at the levels required and for the time period required by the authority as conditions of the award to the business.

c. The contract between the third-party provider and the business specifically requires the third-party provider to submit payroll records to the authority, in the form and content and as frequently as required by the authority, for purposes of verifying that the business's job creation or retention and benefit requirements are being met.

d. The contract between the third-party provider and the business specifically authorizes the authority, or its authorized representatives, to access the third-party provider's records related to the funded project.

e. The business receiving the tax incentives or financial assistance agrees to be contractually liable to the authority for the performance or nonperformance of the third-party provider.

69.8(6) *Remote employees.* Employees in a position with a reasonable connection to a project location who work remotely may be included in the base employment level, as a created job, or as a retained job as established by the authority at the time of application. To determine whether employees who work remotely should be included, the authority will consider a business's policies on establishing remote work locations for employees, reporting structures, percentage of time worked at the project location, and the distance of employees' remote work locations from the project location. Only employees who work remotely within a defined geographic area established by the authority will be included. Whether an employee who works remotely is included in the base employment level, as a created job, or as a retained job pursuant to this subrule shall be solely within the discretion of the authority.

261—69.9(15) Wage requirements. Created or retained jobs shall meet the qualifying wage threshold requirements as established pursuant to this rule and as indicated in an agreement. Jobs that do not meet the qualifying wage threshold requirements will not be counted toward a business's job creation or job retention obligations.

69.9(1) If the business is creating jobs, the business shall demonstrate that the jobs will pay at least 100 percent of the qualifying wage threshold by the contract end date. If the business is retaining jobs, the business shall demonstrate that the jobs will pay at least 120 percent of the qualifying wage threshold from the award date until the contract end date. The authority may establish a higher qualifying wage threshold requirement for a specific project if the quality of jobs is a significant factor in negotiating the award pursuant to rule 261—69.4(15).

69.9(2) The authority will update the qualifying wage thresholds annually each fiscal year. The thresholds will take effect on September 1 of each fiscal year and remain in effect until August 31 of the following fiscal year.

69.9(3) The authority will calculate the qualifying wage threshold as follows:

a. The most current covered wage and employment data available from the department of workforce development will be used.

b. The wage will be computed as a mean wage figure and represented in terms of an hourly wage rate.

c. Only the wages paid by employers for jobs performed within the first two zones of a laborshed area will be included.

d. The wages paid by employers in the following categories will be excluded from the calculation: government, retail trade, health care and social assistance, and accommodations and food service. The wages paid by employers in all other categories will be included in the calculation.

e. To the extent that a laborshed area includes zip codes from states other than Iowa, the wages paid by employers in those zip codes may be included if the department of workforce development has finalized a data-sharing agreement with the state in question and has received the necessary data.

f. Only those wages within two standard deviations of the mean wage will be included.

69.9(4) The authority may establish a qualifying wage threshold requirement lower than those designated pursuant to subrule 69.9(1) if a business located in the county experiences a layoff, closure, or natural disaster that has a significant impact on a community within the county.

a. Factors the authority will consider in determining whether a layoff, closure, or natural disaster has a significant impact on a community within the county include but are not limited to total number of employees impacted, percentage of the applicable laborshed impacted, number of employees impacted as a percentage of population, current unemployment rate, and unemployment rate including the employees affected by a layoff or closure.

b. A city or county shall request the designation of a county as an area that has experienced a significant impact pursuant to this subrule in writing. Such requests and the duration of the designation are subject to approval by the board. Requests may be made simultaneously with submission of a project application that would qualify for a lower qualifying wage threshold requirement pursuant to this subrule if the request is approved.

69.9(5) The authority maintains a list of areas qualifying for a lower wage threshold designated pursuant to subrule 69.9(4).

69.9(6) To determine the wages paid to the employees of an eligible business, the authority will include only monetary compensation, represented in terms of an hourly rate, paid by an employer to an employee for work or services provided, typically on a weekly or biweekly basis. The wage will not include nonregular forms of compensation, such as bonuses, unusual overtime pay, commissions, stock options, pensions, retirement or death benefits, unemployment benefits, life or other insurance, or other fringe benefits.

These rules are intended to implement Iowa Code chapter 15, subchapter II, part 33, as enacted by 2025 Iowa Acts, Senate File 657, and section 15A.1.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

ARC 9859C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rulemaking related to nursing facilities, intermediate care facilities for persons with an intellectual disability, and services in psychiatric institutions

The Department of Health and Human Services hereby amends Chapter 81, "Nursing Facilities," Chapter 82, "Intermediate Care Facilities for Persons with an Intellectual Disability," and Chapter 85, "Services in Psychiatric Institutions," Iowa Administrative Code.

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, 2025 Iowa Acts, House File 1049.

Purpose and Summary

This rulemaking implements 2025 Iowa Acts, House File 1049, section 19, which increases the personal needs allowance described in Iowa Code chapters 81, 82, and 85 from $50 to $55.

In addition, this rulemaking updates incorrect cross-references in subrule 81.13(2).

All references to Iowa Code section 249A.30A herein are to that section as amended by 2025 Iowa Acts, House File 1049.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025, as **ARC 9642C**. Public hearings were held on the following date:

- November 18, 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 December 3, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa beyond the $330,513 that was allocated to implement the personal needs allowance increase outlined in Sections 18 and 19 of 2025 Iowa Acts, House File 1049.

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 February 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Amend subrule 81.13(2) as follows:

81.13(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections, appeals, and licensing will, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of paragraph ~~81.11(19)*"e"*~~ 81.11(19)*"b"* and subrule ~~81.14(1)~~ 81.13(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections, appeals, and licensing approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections, appeals, and licensing will determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of ~~81.14(3)~~ subrule 81.13(3).

2. A nurse aide competency evaluation program meets the requirements of ~~81.14(4)~~ subrule 81.13(4).

(2) Except as provided by paragraph ~~81.14(2)*"f,"*~~ 81.13(2)*"f,"* the department of inspections, appeals, and licensing will not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility that, in the previous two years:

1. to 7. No change.

c. to *e.* No change.

f. An exception to subparagraph ~~81.14(2)*"b"*(2)~~ 81.13(2)*"b"*(2) may be granted by the department of inspections, appeals, and licensing for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) to (10) No change.

ITEM 2. Amend rule 441—81.18(249A) as follows:

441—81.18(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than ~~$50~~ $55 per month shall receive a state-funded payment from the department for the difference between that countable income and ~~$50~~ $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

ITEM 3. Amend rule 441—82.16(249A) as follows:

441—82.16(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than ~~$50~~ $55 per month will receive a state-funded payment from the department for the difference between that countable income and ~~$50~~ $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

ITEM 4. Amend rule 441—85.20(249A) as follows:

441—85.20(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness who has countable income for purposes of rule 441—75.16(249A) of less than ~~$50~~ $55 per month will receive a state-funded payment from the department for the difference between that countable income and ~~$50~~ $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

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ARC 9860C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rulemaking related to subsidized adoptions

The Department of Health and Human Services hereby amends Chapter 201, "Subsidized Adoptions," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 600.17 through 600.23.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, 2025 Iowa Acts, House File 1049.

Purpose and Summary

This rulemaking implements 2025 Iowa Acts, House File 1049, section 22, by adding an appropriated increase in foster care and subsidized adoption rates to the Iowa Administrative Code. The Subsidized Adoption Program provides financial assistance to interested adoptive parents capable of providing suitable care but lacking in necessary economic resources.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025, as **ARC 9640C**. Public hearings were held on the following date:

- November 18, 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 December 3, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa beyond the $148,232 appropriated in the underlying legislation.

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 February 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Amend paragraphs **201.5(6)"a"** and **201.5(6)"b"** as follows:

a. The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found in 441—subrule 156.6(1) and 441—paragraph 156.6(4)*"f"* for eligible adoptions that take place on or after July 1, ~~2024~~ 2025. Eligible subsidized and future subsidized adoptions that took place on June 30, ~~2024~~ 2025, or before will remain on the basic rate in effect on June 30, ~~2024~~ 2025.

b. Basic rate effective ~~June 30, 2024~~ July 1, 2025:

Age of child	Daily rate
0 through 5	~~$16.78~~ $18.50
6 through 11	~~$17.45~~ $19.24

12 through 15	~~$19.10~~ $21.06
16 or older	~~$19.35~~ $21.34

[Filed 12/3/25, effective 2/1/26]
[Published 12/24/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

ARC 9861C

TRANSPORTATION DEPARTMENT[761]

Adopted and Filed

Rulemaking related to city requests for closure of primary road extensions

The Transportation Department hereby rescinds Chapter 151, "City Requests for Closure of Primary Road Extensions," Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 307.12(1)"j."

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 321.348.

Purpose and Summary

The Department is permanently rescinding Chapter 151 because there is no specific rulemaking authority within the Iowa Code that requires these rules. The Department is proposing to instead publish an instructional memorandum that will be available on the Department's website to provide guidance for the requirements and procedures for closing primary road extensions in cities for reasons other than fire, construction, or repair.

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 9451C**. Public hearings were held on the following date:

- August 26, 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 14, 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 761—Chapter 11.

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 28, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **761—Chapter 151**.

[Filed 11/24/25, effective 1/28/26]
[Published 12/24/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

ARC 9862C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to definitions

The Workforce Development Department hereby adopts new Chapter 48, "Definitions," 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 chapter is to define terms used in the Department's rules.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025, as **ARC 9644C**. Public hearings were held on the following date:

- November 18, 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 December 3, 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 January 28, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 871—Chapter 48:

CHAPTER 48
DEFINITIONS

871—48.1(84A,84B) Definitions. As used in this title, unless the context otherwise requires:

"CFR" means Code of Federal Regulations.

"Chief elected official" means designated representative of the units of local government joining through a 28E agreement, pursuant to Section 107(c)(1)(B) of the federal Workforce Innovation and Opportunity Act (WIOA), for the purpose of sharing liability and responsibility in accordance with Title I of the WIOA. The chief elected official is the chair of the county board of supervisors or a designee from within the county board of supervisors for each county.

"Department" means the department of workforce development, which has been designated as the state workforce agency on behalf of the governor.

This rule is intended to implement Iowa Code chapters 84A and 84B.

[Filed 12/3/25, effective 1/28/26]
[Published 12/24/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

ARC 9863C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to employment and training services division

The Workforce Development Department hereby adopts new Chapter 49, "Employment and Training Services Division," 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 these rules is to inform the public of the mission and structure of the Employment and Training Division of the Department.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025, as **ARC 9647C**. Public hearings were held on the following date:

- November 18, 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 December 3, 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 January 28, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 871—Chapter 49:

CHAPTER 49
EMPLOYMENT AND TRAINING SERVICES DIVISIONS

871—49.1(84A,84B) Mission and organization.

49.1(1) *Mission.* The employment and training services division's work is to provide reemployment services to Iowa job seekers and employers through various federal and state workforce programs.

49.1(2) *Operation and administration.* Divisions are under the direction of a division administrator who reports to the deputy director. The division administrators direct and lead the work of their respective divisions.

871—49.2(84A,84B) Complaint process. The Workforce Innovation Opportunity Act (WIOA) complaint process for all complaints and grievances filed by participants and other interested persons affected by the statewide WIOA Title I programs is accessible on the Iowa workforce development website.

These rules are intended to implement Iowa Code chapter 84A.

[Filed 12/3/25, effective 1/28/26]
[Published 12/24/25]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

ARC 9864C

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Adopted and Filed

Rulemaking related to the workforce investment act program

The Workforce Development Department hereby rescinds Chapter 53, "Iowa Workforce Investment Act 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 96 and section 84A.1 and Executive Order 11.

Purpose and Summary

The purpose of this rulemaking is to remove outdated rules from the Iowa Administrative Code.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on October 29, 2025, as **ARC 9643C**. Public hearings were held on the following date:

- November 18, 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 December 3, 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 January 28, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind and reserve **871—Chapter 53**.

[Filed 12/3/25, effective 1/28/26]
[Published 12/24/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/24/25.

State of Iowa
Executive Department

IN THE NAME AND BY THE AUTHORITY OF THE STATE OF IOWA

EXECUTIVE ORDER NUMBER SIXTEEN

WHEREAS, the year 2026 marks the 250th anniversary of the signing of the Declaration of Independence and the formation of the United States of America;

WHEREAS, the President of the United States on January 29, 2025, issued Executive Order 14189 titled "*Celebrating America's 250th Birthday*" to provide a grand celebration worthy of the 250th anniversary of American Independence which occurs on July 4, 2026.

WHEREAS, the State of Iowa, Iowans and Iowa's communities, cultural institutions, historical societies and local government, are proud partners in the remembrance of the events of the American Revolutionary War and those who fought so bravely for our country's independence;

WHEREAS, a task force can serve as a valuable resource to the State of Iowa to advise the Governor on Iowa's participation in this celebration.

NOW, THEREFORE, I, KIMBERLY K. REYNOLDS, Governor of the State of Iowa, by virtue of the power and authority vested in me by the Constitution and statutes of the State of Iowa do hereby **ORDER** and **DIRECT** the following:

MISSION

I. The Governor's Task Force on Celebrating America's 250th Birthday ("Task Force Celebrating 250") shall plan, encourage, develop, and coordinate the commemoration of the 250th anniversary of the founding of the United States, and recognize Iowa's integral role in that event and the impact of its people on the nation's past, present, and future.

ORGANIZATION AND OPERATION

I. Task Force Celebrating 250 Established: the Governor's Task Force Celebrating 250 is hereby established. The task force shall consist of twenty-one (21) members appointed by the Governor. The members are:

(i) Lieutenant Governor;
(ii) Secretary of Agriculture;
(iii) Secretary of State;
(iv) Director of the Department of Administrative Services;
(v) Director of the Department of Management;
(vi) Director of the Department of Economic Development;
(vii) Director of the Department of Education;
(viii) Director of the Department of Natural Resources;
(ix) Director of the Department of Public Defense;
(x) Director of the Department Veteran Affairs;
(xi) Chief Executive Officer of the Iowa State Fair Board;
(xii) Six (6) non-government members, including a member selected by the Iowa Society of the Daughters of the American Revolution and a member selected by the Iowa Society of the Sons of the American Revolution;
(xiii) One Republican member of the house of representatives, to be selected by the speaker of the house of representatives, and one Democrat member of the house of representatives, to be selected by the minority leader of the

house of representatives, both of whom shall serve in an *ex officio* capacity; and

(xiv) One Republican member of the senate, to be selected by the president of the senate, and one Democrat member of the senate, to be selected by the minority leader of the senate, both of whom shall serve in an *ex officio* capacity.

II. Chairperson: the Lieutenant Governor shall serve as chairperson and preside over task force meetings. The Secretary of Agriculture shall serve as vice-chairperson in the absence of the chairperson.

III. Meetings: the task force shall hold its first meeting when called to do so by the Lieutenant Governor.

IV. Service as Members: each appointed member of the task force shall serve at the pleasure of the Governor without compensation.

V. Staffing and Support: staffing and administration assistance for the task force may be provided by the Governor's office and/or by other agencies, persons, or organizations, from time to time, as deemed necessary and approved by the Governor. The task force cannot enter into any contracts nor expend any public money.

VI. Public Portal: the Division of Information Technology for the Department of Management shall work with the task force to establish a public portal. Further, the task force will operate an X social media account using the handle @America250IA where the public can also provide feedback and recommendations.

PURPOSE AND DUTIES

I. Duties: the duties of the task force shall include, but are not limited to, advising the Governor on:

a. Planning, coordinating, and implementing a program to commemorate the 250th anniversary of the founding of the United States in the year 2026, specifically highlighting the role of Iowa and Iowans in, and the events succeeding, the historic event;

b. Coordinating with federal, state, and local agencies on projects to welcome regional, national, and international opportunities;

c. Giving due consideration to related plans and programs developed by federal, state, local, and private groups;

d. Showcasing all counties in this state; and

e. Drawing attention to the achievements, honors, innovations, and impacts of Iowans; and

f. Addressing any other matters pertaining to the scope of this Executive Order.

II. Final Report: no later than 120 days after the effective date of this order, the task force shall submit a final report to the Governor. The final report must include detailed timeline of the task force's plan for the event through December 31, 2026.

III. Gifts of Money. Pursuant to the authority provided in Iowa Code section 565.3, I accept, on behalf of the state, any gifts of money made to the state that are to be used for purposes of celebrating America's 250th birthday.

IMPLEMENTATION AND INTERPRETATION

I. All departments, agencies, boards, commissions, or other political subdivisions of any state and local governments shall cooperate fully with requests made by the task force. The task force may seek the expertise and services of individuals and entities outside of

its membership for research, advice, and other needs, as necessary or appropriate, to accomplish its mission.

II. All work of the task force shall be done in a manner consistent with laws and regulations of the State of Iowa, and of the laws and regulations of the United States of America.

III. This Executive Order shall be interpreted in accordance with all applicable laws and regulations and shall not supersede any laws or regulations in place as of its effective date. If any provision of this Executive Order is found to be invalid, unenforceable, or otherwise contrary to applicable law, then the remaining provisions of this Executive Order, as applied to any person or circumstance, shall continue in full force and effect, and shall not be affected by such finding of invalidity or unenforceability.

IV. This Executive Order does not create any right or benefit, substantive or procedural enforceable at law or in equity, by any party against the State of Iowa, its departments, agencies, or political subdivisions, or its officers, employees, agents, or any other person.

V. This Executive Order shall apply prospectively only as of its effective date.

VI. This Executive Order shall expire upon the submission of the final report to the Governor unless extended, in writing, by the Governor.



IN TESTIMONY WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY NAME AND CAUSED THE GREAT SEAL OF THE STATE OF IOWA TO BE AFFIXED AT DES MOINES, IOWA THIS SIXTH DAY OF NOVEMBER IN THE YEAR OF OUR LORD TWO THOUSAND TWENTY-FIVE.

Kim Reynolds

KIMBERLY K. REYNOLDS
GOVERNOR

ATTEST:

Paul D. Pate

PAUL D. PATE
SECRETARY OF STATE