



# IOWA ADMINISTRATIVE BULLETIN

*Published Biweekly*

VOLUME XLVIII  
May 27, 2026

NUMBER 25  
Pages 8275 to 8823

## CONTENTS IN THIS ISSUE

Pages 8339 to 8823 include **ARC 0296D** to **ARC 0324D**

### AGENDA

Administrative rules review committee. . . . . 8278

### ALL AGENCIES

Agency identification numbers. . . . . 8282  
Citation of administrative rules. . . . . 8277  
Schedule. . . . . 8281

### BANKING DIVISION[187]

Regulatory Analysis, Electronic transfer  
of funds, ch 10 **RA 26-77** . . . . . 8329

### ECONOMIC DEVELOPMENT AUTHORITY[261]

Filed, Iowa energy center, ch 403  
**ARC 0309D** . . . . . 8456  
Filed, Alternate energy revolving loan  
program, ch 405 **ARC 0310D** . . . . . 8458  
Filed, Energy infrastructure revolving  
loan program, ch 406 **ARC 0311D** . . . . . 8461

### HUMAN SERVICES DEPARTMENT[441]

Regulatory Analysis, Civil commitment  
unit for sexual offenders, ch 31 **RA 26-67** . . . 8284  
Notice, Uniform rules on agency  
procedure, amend ch 9; adopt  
chs 2504 to 2506 **ARC 0303D** . . . . . 8339  
Notice, Social casework, rescind ch 131  
**ARC 0301D** . . . . . 8342  
Notice, In-home health-related care,  
ch 177 **ARC 0302D** . . . . . 8343  
Filed Emergency, Uniform rules on  
agency procedure, amend ch 9; adopt  
chs 2504 to 2506 **ARC 0300D** . . . . . 8434

Filed, Managed care, ch 73 **ARC 0312D** . . . . . 8465  
Filed, Iowa health and wellness plan,  
ch 74 **ARC 0313D** . . . . . 8478  
Filed, Conditions of participation for  
providers of medical and remedial  
care, ch 77 **ARC 0314D** . . . . . 8484  
Filed, Amount, duration and scope of  
medical and remedial services, ch 78  
**ARC 0315D** . . . . . 8523  
Filed, Other policies relating to  
providers of medical and remedial  
care, ch 79 **ARC 0316D** . . . . . 8656  
Filed, Procedure and method of  
payment, ch 80 **ARC 0317D** . . . . . 8736  
Filed, Medicaid waiver services, ch 83  
**ARC 0318D** . . . . . 8740  
Filed, Fee-for-service case management,  
ch 90 **ARC 0319D** . . . . . 8790  
Filed, Certificate of need program;  
standards for certificate of need  
review, chs 123, 124 **ARC 0320D** . . . . . 8795

### INSPECTIONS AND APPEALS DEPARTMENT[481]

Regulatory Analysis, Social and  
charitable gambling—notification of  
prize winner, raffle rules,  
100.10(1), 100.16(4) **RA 26-68** . . . . . 8288  
Regulatory Analysis, Appraisal  
management companies, ch 2050  
**RA 26-69** . . . . . 8291

|                                                                                                                                                                       |      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| Notice, Speech pathologists and audiologists—interstate compact, background checks, fees, amendments to ch 740 <b>ARC 0324D</b> . . . . .                             | 8350 |
| <b>INSURANCE DIVISION[191]</b>                                                                                                                                        |      |
| INSURANCE AND FINANCIAL SERVICES DEPARTMENT[181]“umbrella”                                                                                                            |      |
| Notice, Licensing of public adjusters—financial responsibility, 55.10 <b>ARC 0304D</b> . . . . .                                                                      | 8353 |
| Filed Emergency, Licensing of public adjusters—financial responsibility, 55.10 <b>ARC 0308D</b> . . . . .                                                             | 8448 |
| <b>IOWA PUBLIC EMPLOYEES’ RETIREMENT SYSTEM[495]</b>                                                                                                                  |      |
| Filed, Contribution rates—all member classes, 4.6 <b>ARC 0323D</b> . . . . .                                                                                          | 8814 |
| <b>PUBLIC HEALTH DEPARTMENT[641]</b>                                                                                                                                  |      |
| Regulatory Analysis, Emergency medical services—certification, renewal, continuing education, 131.1, 131.2(1), 131.4(2), 131.5, 131.6(4)“e” <b>RA 26-70</b> . . . . . | 8301 |
| <b>RACING AND GAMING COMMISSION[491]</b>                                                                                                                              |      |
| INSPECTIONS AND APPEALS DEPARTMENT[481]“umbrella”                                                                                                                     |      |
| Notice, Declaratory orders—modifications to uniform rules; contested cases—modifications to uniform rules, chs 2503, 2506 <b>ARC 0297D</b> . . . . .                  | 8355 |
| Filed Emergency, Declaratory orders—modifications to uniform rules; contested cases—modifications to uniform rules, chs 2503, 2506 <b>ARC 0296D</b> . . . . .         | 8450 |
| <b>REVENUE DEPARTMENT[701]</b>                                                                                                                                        |      |
| Notice of electric and natural gas delivery tax rate changes. . . . .                                                                                                 | 8430 |
| Filed, Renaming of the legal services division, amendments to chs 2 to 4, 7, 11, 19 <b>ARC 0321D</b> . . . . .                                                        | 8816 |
| <b>TRANSPORTATION DEPARTMENT[761]</b>                                                                                                                                 |      |
| Regulatory Analysis, Motor vehicle records—driver’s privacy protection and electronic communications, amendments to ch 301 <b>RA 26-71</b> . . . . .                  | 8306 |
| Regulatory Analysis, International fuel tax agreement—update of adoption by reference, 505.2(2) <b>RA 26-72</b> . . . . .                                             | 8310 |
| Regulatory Analysis, Driver’s licenses—special licenses and permits, 602.3 <b>RA 26-73</b> . . . . .                                                                  | 8313 |
| Regulatory Analysis, License issuance—information technology system, 605.2 to 605.5, 605.7 to 605.10, 605.14, 605.15 <b>RA 26-74</b> . . . . .                        | 8316 |
| Regulatory Analysis, OWI and implied consent—information technology system, 620.3(2)“b,” 620.4(2), 620.7 <b>RA 26-75</b> . . . . .                                    | 8324 |
| Regulatory Analysis, Accident reporting requirements—information technology system, 640.3 <b>RA 26-76</b> . . . . .                                                   | 8327 |
| <b>TREASURER OF STATE</b>                                                                                                                                             |      |
| Notice—Public funds interest rates. . . . .                                                                                                                           | 8431 |
| <b>USURY</b>                                                                                                                                                          |      |
| Notice. . . . .                                                                                                                                                       | 8432 |
| <b>UTILITIES COMMISSION[199]</b>                                                                                                                                      |      |
| Notice, Service supplied by rate-regulated gas utilities, ch 19 <b>ARC 0306D</b> . . . . .                                                                            | 8357 |
| Notice, Regulation of electric cooperatives and municipal electric utilities under Iowa Code chapter 476, ch 27 <b>ARC 0307D</b> . . . . .                            | 8396 |
| Notice, Regulation of municipal and certain other gas utilities under Iowa Code chapter 476, ch 28 <b>ARC 0305D</b> . . . . .                                         | 8412 |
| <b>VETERINARY MEDICINE BOARD[811]</b>                                                                                                                                 |      |
| Filed, Discipline—civil penalties, 10.6 <b>ARC 0322D</b> . . . . .                                                                                                    | 8822 |
| <b>WORKFORCE DEVELOPMENT DEPARTMENT[871]</b>                                                                                                                          |      |
| Notice, Contested cases, ch 2506 <b>ARC 0298D</b> . . . . .                                                                                                           | 8428 |
| Filed Emergency, Contested cases, ch 2506 <b>ARC 0299D</b> . . . . .                                                                                                  | 8453 |

## 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.

JACK EWING, Administrative Code Editor

Telephone: 515.281.6048

Email: [Jack.Ewing@legis.iowa.gov](mailto:Jack.Ewing@legis.iowa.gov)

Publications Editing Office (Administrative Code)

Telephone: 515.281.3355

Email: [AdminCode@legis.iowa.gov](mailto:AdminCode@legis.iowa.gov)

## CITATION of Administrative Rules

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

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

|                          |                      |
|--------------------------|----------------------|
| 441 IAC 79               | (Chapter)            |
| 441 IAC 79.1             | (Rule)               |
| 441 IAC 79.1(1)          | (Subrule)            |
| 441 IAC 79.1(1)“a”       | (Paragraph)          |
| 441 IAC 79.1(1)“a”(1)    | (Subparagraph)       |
| 441 IAC 79.1(1)“a”(1)“1” | (Numbered paragraph) |

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

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

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

The Administrative Rules Review Committee will hold its regular, statutory meeting on [DATE], at [TIME] in Room [XXX], State Capitol, Des Moines, Iowa. For more information, contact Jack Ewing at [jack.ewing@legis.iowa.gov](mailto:jack.ewing@legis.iowa.gov). The following rules will be reviewed:

#### **AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]**

On-site containment of pesticides, fertilizers and beneficial substances, ch 44 Notice **ARC 0251D** ..... 5/13/26

#### **ECONOMIC DEVELOPMENT AUTHORITY[261]**

Sustainable aviation fuel production tax credit program, ch 80 Filed **ARC 0258D** ..... 5/13/26

Iowa energy center, ch 403 Filed **ARC 0309D** ..... 5/27/26

Alternate energy revolving loan program, ch 405 Filed **ARC 0310D** ..... 5/27/26

Energy infrastructure revolving loan program, ch 406 Filed **ARC 0311D** ..... 5/27/26

#### **EDUCATION DEPARTMENT[281]**

Dispute resolution: practice before mediators and administrative law judges, 120.811 Filed **ARC 0259D** ..... 5/13/26

#### **HUMAN SERVICES DEPARTMENT[441]**

Uniform rules on agency procedure, amend ch 9; adopt chs 2504 to 2506 Notice **ARC 0303D** Filed

Emergency **ARC 0300D** ..... 5/27/26

Autism support program, ch 22 Filed **ARC 0260D** ..... 5/13/26

Managed care, ch 73 Filed **ARC 0312D** ..... 5/27/26

Iowa health and wellness plan, ch 74 Filed **ARC 0313D** ..... 5/27/26

Conditions of participation for providers of medical and remedial care, ch 77 Filed **ARC 0314D** ..... 5/27/26

Amount, duration and scope of medical and remedial services, ch 78 Filed **ARC 0315D** ..... 5/27/26

Other policies relating to providers of medical and remedial care, ch 79 Filed **ARC 0316D** ..... 5/27/26

Procedure and method of payment, ch 80 Filed **ARC 0317D** ..... 5/27/26

Medicaid waiver services, ch 83 Filed **ARC 0318D** ..... 5/27/26

Fee-for-service case management, ch 90 Filed **ARC 0319D** ..... 5/27/26

Child care center employees—physical examination, training credits, 109.9(1)“b” Notice **ARC 0254D** ..... 5/13/26

Certificate of need program; standards for certificate of need review, chs 123, 124 Filed **ARC 0320D** ..... 5/27/26

Social casework, rescind ch 131 Notice **ARC 0301D** ..... 5/27/26

Interstate compact on the placement of children, ch 142 Notice **ARC 0253D** ..... 5/13/26

Interstate compact for juveniles, ch 143 Notice **ARC 0252D** ..... 5/13/26

Adolescent pregnancy prevention and services to pregnant and parenting adolescents programs, rescind  
ch 163 Filed **ARC 0261D** ..... 5/13/26

In-home health-related care, ch 177 Notice **ARC 0302D** ..... 5/27/26

#### **INSPECTIONS AND APPEALS DEPARTMENT[481]**

Boiler and pressure vessel board—waivers, contested cases, 380.5 to 380.7 Notice **ARC 0256D** Filed

Emergency **ARC 0255D** ..... 5/13/26

Speech pathologists and audiologists—interstate compact, background checks, fees, amendments to  
ch 740 Notice **ARC 0324D** ..... 5/27/26

#### **INSURANCE DIVISION[191]**

INSURANCE AND FINANCIAL SERVICES DEPARTMENT[181]“umbrella”

Licensing of public adjusters—financial responsibility, 55.10 Notice **ARC 0304D** Filed Emergency **ARC 0308D** .. 5/27/26

#### **IOWA FINANCE AUTHORITY[265]**

Title guaranty division, ch 9 Filed **ARC 0262D** ..... 5/13/26

State housing trust fund—allocation plan, 19.1(1)“a” Notice **ARC 0257D** ..... 5/13/26

#### **IOWA PUBLIC EMPLOYEES’ RETIREMENT SYSTEM[495]**

Contribution rates—all member classes, 4.6 Filed **ARC 0323D** ..... 5/27/26

#### **NATURAL RESOURCE COMMISSION[571]**

NATURAL RESOURCES DEPARTMENT[561]“umbrella”

Licenses—fees, 15.10 Filed **ARC 0263D** ..... 5/13/26

Lifetime fur harvester permit—disabled veterans, 15.10(1) Filed **ARC 0264D** ..... 5/13/26

Enclosure of docks, 16.3(7), 16.7 Filed **ARC 0265D** ..... 5/13/26

Unprotected nongame, ch 76 Filed **ARC 0266D** ..... 5/13/26

Endangered and threatened plant and animal species, ch 77 Filed **ARC 0267D** ..... 5/13/26

Ginseng harvesting and sale, ch 78 Filed **ARC 0268D** ..... 5/13/26

|                                                                                              |              |                  |         |
|----------------------------------------------------------------------------------------------|--------------|------------------|---------|
| Fish stocking procedures and fees for private waters, rescind ch 79                          | <u>Filed</u> | <b>ARC 0269D</b> | 5/13/26 |
| Salvage of fish and game, ch 80                                                              | <u>Filed</u> | <b>ARC 0270D</b> | 5/13/26 |
| Fishing regulations, ch 81                                                                   | <u>Filed</u> | <b>ARC 0271D</b> | 5/13/26 |
| Commercial fishing, ch 82                                                                    | <u>Filed</u> | <b>ARC 0272D</b> | 5/13/26 |
| Scuba and skin spearing of rough fish, ch 83                                                 | <u>Filed</u> | <b>ARC 0273D</b> | 5/13/26 |
| Promiscuous fishing, ch 84                                                                   | <u>Filed</u> | <b>ARC 0274D</b> | 5/13/26 |
| Turtles, ch 86                                                                               | <u>Filed</u> | <b>ARC 0275D</b> | 5/13/26 |
| Mussel regulations, ch 87                                                                    | <u>Filed</u> | <b>ARC 0276D</b> | 5/13/26 |
| Aquaculture, ch 89                                                                           | <u>Filed</u> | <b>ARC 0277D</b> | 5/13/26 |
| Aquatic invasive species, ch 90                                                              | <u>Filed</u> | <b>ARC 0278D</b> | 5/13/26 |
| Commercial use of captive-reared waterfowl, ch 93                                            | <u>Filed</u> | <b>ARC 0279D</b> | 5/13/26 |
| Game harvest reporting and landowner-tenant registration, ch 95                              | <u>Filed</u> | <b>ARC 0280D</b> | 5/13/26 |
| Resident turkey hunting licenses—valid until filled, 98.1(1)“d,” 98.2, 98.3(2)               | <u>Filed</u> | <b>ARC 0281D</b> | 5/13/26 |
| Mobile radio transmitters, rescind ch 103                                                    | <u>Filed</u> | <b>ARC 0282D</b> | 5/13/26 |
| Hunting preserves, rescind chs 104, 115; ch 112                                              | <u>Filed</u> | <b>ARC 0283D</b> | 5/13/26 |
| Natural resources collector permits: research, education and wildlife rehabilitation, ch 111 | <u>Filed</u> | <b>ARC 0284D</b> | 5/13/26 |
| Restitution for pollution causing injury to wild animals, ch 113                             | <u>Filed</u> | <b>ARC 0285D</b> | 5/13/26 |
| Help us stop hunger program administration, ch 116                                           | <u>Filed</u> | <b>ARC 0286D</b> | 5/13/26 |

### **PRESERVES, STATE ADVISORY BOARD FOR[575]**

NATURAL RESOURCES DEPARTMENT[561]“umbrella”

|                                                     |              |                  |         |
|-----------------------------------------------------|--------------|------------------|---------|
| Agency realignment, transfer ch 1; rescind chs 2, 3 | <u>Filed</u> | <b>ARC 0287D</b> | 5/13/26 |
|-----------------------------------------------------|--------------|------------------|---------|

### **PUBLIC HEALTH DEPARTMENT[641]**

Permits to operate ionizing radiation producing machines or administer radioactive materials for medical imaging,

|                                                |              |                  |         |
|------------------------------------------------|--------------|------------------|---------|
| ch 38                                          | <u>Filed</u> | <b>ARC 0288D</b> | 5/13/26 |
| Radon testing and analysis requirements, ch 43 | <u>Filed</u> | <b>ARC 0289D</b> | 5/13/26 |
| Radon mitigation requirements, ch 44           | <u>Filed</u> | <b>ARC 0290D</b> | 5/13/26 |

### **PUBLIC SAFETY DEPARTMENT[661]**

|                                                                                  |               |                  |         |
|----------------------------------------------------------------------------------|---------------|------------------|---------|
| Vehicle impoundment, rescind ch 6                                                | <u>Notice</u> | <b>ARC 0293D</b> | 5/13/26 |
| Safety and hazardous materials regulations—update of adoption by reference, 22.1 | <u>Filed</u>  | <b>ARC 0292D</b> | 5/13/26 |
| Criminal intelligence information, ch 81                                         | <u>Notice</u> | <b>ARC 0294D</b> | 5/13/26 |
| Wireless communications service provider database, ch 87                         | <u>Notice</u> | <b>ARC 0295D</b> | 5/13/26 |

### **RACING AND GAMING COMMISSION[491]**

INSPECTIONS AND APPEALS DEPARTMENT[481]“umbrella”

Declaratory orders—modifications to uniform rules; contested cases—modifications to uniform rules,

|                |               |                  |                        |                  |         |
|----------------|---------------|------------------|------------------------|------------------|---------|
| chs 2503, 2506 | <u>Notice</u> | <b>ARC 0297D</b> | <u>Filed Emergency</u> | <b>ARC 0296D</b> | 5/27/26 |
|----------------|---------------|------------------|------------------------|------------------|---------|

### **REVENUE DEPARTMENT[701]**

|                                                                                      |              |                  |         |
|--------------------------------------------------------------------------------------|--------------|------------------|---------|
| Renaming of the legal services division, amendments to chs 2 to 4, 7, 11, 19         | <u>Filed</u> | <b>ARC 0321D</b> | 5/27/26 |
| Barrel programs—products split between class “E” retail alcohol licensees, 1001.9(4) | <u>Filed</u> | <b>ARC 0291D</b> | 5/13/26 |

### **UTILITIES COMMISSION[199]**

|                                                                                                   |               |                  |         |
|---------------------------------------------------------------------------------------------------|---------------|------------------|---------|
| Service supplied by rate-regulated gas utilities, ch 19                                           | <u>Notice</u> | <b>ARC 0306D</b> | 5/27/26 |
| Regulation of electric cooperatives and municipal electric utilities under Iowa Code chapter 476, |               |                  |         |
| ch 27                                                                                             | <u>Notice</u> | <b>ARC 0307D</b> | 5/27/26 |
| Regulation of municipal and certain other gas utilities under Iowa Code chapter 476, ch 28        | <u>Notice</u> | <b>ARC 0305D</b> | 5/27/26 |

### **VETERINARY MEDICINE BOARD[811]**

|                                  |              |                  |         |
|----------------------------------|--------------|------------------|---------|
| Discipline—civil penalties, 10.6 | <u>Filed</u> | <b>ARC 0322D</b> | 5/27/26 |
|----------------------------------|--------------|------------------|---------|

### **WORKFORCE DEVELOPMENT DEPARTMENT[871]**

|                          |               |                  |                        |                  |         |
|--------------------------|---------------|------------------|------------------------|------------------|---------|
| Contested cases, ch 2506 | <u>Notice</u> | <b>ARC 0298D</b> | <u>Filed Emergency</u> | <b>ARC 0299D</b> | 5/27/26 |
|--------------------------|---------------|------------------|------------------------|------------------|---------|

## 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 Kara Warme  
Chair  
Senate District 26

Representative Chad Ingels  
Vice Chair  
House District 68

Senator Mike Bousset  
Senate District 21

Representative Austin Harris  
House District 26

Senator Dan Dawson  
Senate District 10

Representative Joshua Meggers  
House District 54

Senator Janet Petersen  
Senate District 18

Representative Amy Nielsen  
House District 85

Senator Cindy Winckler  
Senate District 49

Representative Rick Olson  
House District 39

Jack Ewing  
**Administrative Code Editor**  
Capitol  
Des Moines, Iowa 50319  
Telephone: 515.281.6048  
Fax: 515.281.8451  
Email: [jack.ewing@legis.iowa.gov](mailto:jack.ewing@legis.iowa.gov)

Stan Thompson  
**Administrative Rules Coordinator**  
Governor's Ex Officio Representative  
Capitol, Room 18  
Des Moines, Iowa 50319  
Telephone: 515.281.5211

## Schedule for Rulemaking—2026

| REGULATORY ANALYSIS SUBMISSION DEADLINE | REGULATORY ANALYSIS PUB. DATE | HEARING AND COMMENTS 20 DAYS | FIRST POSSIBLE NOTICE SUBMISSION DEADLINE | NOTICE PUB. DATE | HEARING AND COMMENTS 20 DAYS | FIRST POSSIBLE ADOPTION DATE 35 DAYS | FIRST POSSIBLE ADOPTED FILING SUBMISSION DEADLINE | ADOPTED PUB. DATE | FIRST POSSIBLE EFFECTIVE DATE 35 DAYS | FIRST POSSIBLE EXPIRATION OF NOTICE 180 DAYS |
|-----------------------------------------|-------------------------------|------------------------------|-------------------------------------------|------------------|------------------------------|--------------------------------------|---------------------------------------------------|-------------------|---------------------------------------|----------------------------------------------|
| <b>**Dec. 17 '25**</b>                  | Jan. 7                        | Jan. 27                      | Jan. 29                                   | Feb. 18          | Mar. 10                      | Mar. 25                              | Mar. 26                                           | Apr. 15           | May 20                                | Aug. 17                                      |
| <b>**Dec. 31 '25**</b>                  | Jan. 21                       | Feb. 10                      | Feb. 12                                   | Mar. 4           | Mar. 24                      | Apr. 8                               | Apr. 9                                            | Apr. 29           | June 3                                | Aug. 31                                      |
| Jan. 15                                 | Feb. 4                        | Feb. 24                      | Feb. 26                                   | Mar. 18          | Apr. 7                       | Apr. 22                              | Apr. 23                                           | May 13            | June 17                               | Sep. 14                                      |
| Jan. 29                                 | Feb. 18                       | Mar. 10                      | Mar. 12                                   | Apr. 1           | Apr. 21                      | May 6                                | <b>**May 6**</b>                                  | May 27            | July 1                                | Sep. 28                                      |
| Feb. 12                                 | Mar. 4                        | Mar. 24                      | Mar. 26                                   | Apr. 15          | May 5                        | May 20                               | May 21                                            | June 10           | July 15                               | Oct. 12                                      |
| Feb. 26                                 | Mar. 18                       | Apr. 7                       | Apr. 9                                    | Apr. 29          | May 19                       | June 3                               | June 4                                            | June 24           | July 29                               | Oct. 26                                      |
| Mar. 12                                 | Apr. 1                        | Apr. 21                      | Apr. 23                                   | May 13           | June 2                       | June 17                              | <b>**June 17**</b>                                | July 8            | Aug. 12                               | Nov. 9                                       |
| Mar. 26                                 | Apr. 15                       | May 5                        | <b>**May 6**</b>                          | May 27           | June 16                      | July 1                               | July 2                                            | July 22           | Aug. 26                               | Nov. 23                                      |
| Apr. 9                                  | Apr. 29                       | May 19                       | May 21                                    | June 10          | June 30                      | July 15                              | July 16                                           | Aug. 5            | Sep. 9                                | Dec. 7                                       |
| Apr. 23                                 | May 13                        | June 2                       | June 4                                    | June 24          | July 14                      | July 29                              | July 30                                           | Aug. 19           | Sep. 23                               | Dec. 21                                      |
| <b>**May 6**</b>                        | May 27                        | June 16                      | <b>**June 17**</b>                        | July 8           | July 28                      | Aug. 12                              | Aug. 13                                           | Sep. 2            | Oct. 7                                | Jan. 4 '27                                   |
| May 21                                  | June 10                       | June 30                      | July 2                                    | July 22          | Aug. 11                      | Aug. 26                              | <b>**Aug. 26**</b>                                | Sep. 16           | Oct. 21                               | Jan. 18 '27                                  |
| June 4                                  | June 24                       | July 14                      | July 16                                   | Aug. 5           | Aug. 25                      | Sep. 9                               | Sep. 10                                           | Sep. 30           | Nov. 4                                | Feb. 1 '27                                   |
| <b>**June 17**</b>                      | July 8                        | July 28                      | July 30                                   | Aug. 19          | Sep. 8                       | Sep. 23                              | Sep. 24                                           | Oct. 14           | Nov. 18                               | Feb. 15 '27                                  |
| July 2                                  | July 22                       | Aug. 11                      | Aug. 13                                   | Sep. 2           | Sep. 22                      | Oct. 7                               | Oct. 8                                            | Oct. 28           | Dec. 2                                | Mar. 1 '27                                   |
| July 16                                 | Aug. 5                        | Aug. 25                      | <b>**Aug. 26**</b>                        | Sep. 16          | Oct. 6                       | Oct. 21                              | <b>**Oct. 21**</b>                                | Nov. 11           | Dec. 16                               | Mar. 15 '27                                  |
| July 30                                 | Aug. 19                       | Sep. 8                       | Sep. 10                                   | Sep. 30          | Oct. 20                      | Nov. 4                               | <b>**Nov. 4**</b>                                 | Nov. 25           | Dec. 30                               | Mar. 29 '27                                  |
| Aug. 13                                 | Sep. 2                        | Sep. 22                      | Sep. 24                                   | Oct. 14          | Nov. 3                       | Nov. 18                              | <b>**Nov. 18**</b>                                | Dec. 9            | Jan. 13 '27                           | Apr. 12 '27                                  |
| <b>**Aug. 26**</b>                      | Sep. 16                       | Oct. 6                       | Oct. 8                                    | Oct. 28          | Nov. 17                      | Dec. 2                               | <b>**Dec. 2**</b>                                 | Dec. 23           | Jan. 27 '27                           | Apr. 26 '27                                  |
| Sep. 10                                 | Sep. 30                       | Oct. 20                      | <b>**Oct. 21**</b>                        | Nov. 11          | Dec. 1                       | Dec. 16                              | <b>**Dec. 16**</b>                                | Jan. 6 '27        | Feb. 10 '27                           | May 10 '27                                   |
| Sep. 24                                 | Oct. 14                       | Nov. 3                       | <b>**Nov. 4**</b>                         | Nov. 25          | Dec. 15                      | Dec. 30                              | <b>**Dec. 30**</b>                                | Jan. 20 '27       | Feb. 24 '27                           | May 24 '27                                   |
| Oct. 8                                  | Oct. 28                       | Nov. 17                      | <b>**Nov. 18**</b>                        | Dec. 9           | Dec. 29                      | Jan. 13 '27                          | Jan. 14 '27                                       | Feb. 3 '27        | Mar. 10 '27                           | June 7 '27                                   |
| <b>**Oct. 21**</b>                      | Nov. 11                       | Dec. 1                       | <b>**Dec. 2**</b>                         | Dec. 23          | Jan. 12 '27                  | Jan. 27 '27                          | Jan. 28 '27                                       | Feb. 17 '27       | Mar. 24 '27                           | June 21 '27                                  |
| <b>**Nov. 4**</b>                       | Nov. 25                       | Dec. 15                      | <b>**Dec. 16**</b>                        | Jan. 6 '27       | Jan. 26 '27                  | Feb. 10 '27                          | Feb. 11 '27                                       | Mar. 3 '27        | Apr. 7 '27                            | July 5 '27                                   |
| <b>**Nov. 18**</b>                      | Dec. 9                        | Dec. 29                      | <b>**Dec. 30**</b>                        | Jan. 20 '27      | Feb. 9 '27                   | Feb. 24 '27                          | Feb. 25 '27                                       | Mar. 17 '27       | Apr. 21 '27                           | July 19 '27                                  |
| <b>**Dec. 2**</b>                       | Dec. 23                       | Jan. 12 '27                  | Jan. 14 '27                               | Feb. 3 '27       | Feb. 23 '27                  | Mar. 10 '27                          | Mar. 11 '27                                       | Mar. 31 '27       | May 5 '27                             | Aug. 2 '27                                   |
| <b>**Dec. 16**</b>                      | Jan. 6 '27                    | Jan. 26 '27                  | Jan. 28 '27                               | Feb. 17 '27      | Mar. 9 '27                   | Mar. 24 '27                          | Mar. 25 '27                                       | Apr. 14 '27       | May 19 '27                            | Aug. 16 '27                                  |
| <b>**Dec. 30**</b>                      | Jan. 20 '27                   | Feb. 9 '27                   | Feb. 11 '27                               | Mar. 3 '27       | Mar. 23 '27                  | Apr. 7 '27                           | Apr. 8 '27                                        | Apr. 28 '27       | June 2 '27                            | Aug. 30 '27                                  |

## PLEASE NOTE:

Rules will not be accepted by the Publications Editing Office after 12:00 p.m. noon on a submission deadline unless prior approval has been received from the Administrative Rules Coordinator and the Administrative Code Editor. If the submission 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.**

**\*\*Bold and asterisks indicate change of regular submission 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.

ADMINISTRATIVE RULES COORDINATOR[7]  
ADMINISTRATIVE SERVICES DEPARTMENT[11]  
AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]  
    Soil Conservation and Water Quality Division[27]  
ATTORNEY GENERAL[61]  
AUDITOR OF STATE[81]  
BEEF CATTLE PRODUCERS ASSOCIATION, IOWA[101]  
BLIND, DEPARTMENT FOR THE[111]  
CHIEF INFORMATION OFFICER, OFFICE OF THE[129]  
OMBUDSMAN[141]  
CIVIL RIGHTS, OFFICE OF[161]  
INSURANCE AND FINANCIAL SERVICES DEPARTMENT[181]  
    Banking Division[187]  
    Credit Union Division[189]  
    Insurance Division[191]  
    Professional Licensing and Regulation Bureau[193]  
        Accountancy Examining Board[193A]  
        Architectural Examining Board[193B]  
        Engineering and Land Surveying Examining Board[193C]  
        Landscape Architectural Examining Board[193D]  
        Real Estate Commission[193E]  
        Real Estate Appraiser Examining Board[193F]  
        Interior Design Examining Board[193G]  
UTILITIES COMMISSION[199]  
CORRECTIONS DEPARTMENT[201]  
    Parole Board[205]  
CULTURAL AFFAIRS DEPARTMENT[221]  
    Historical Division[223]  
ECONOMIC DEVELOPMENT AUTHORITY[261]  
    City Development Board[263]  
IOWA FINANCE AUTHORITY[265]  
EDUCATION DEPARTMENT[281]  
    Educational Examiners Board[282]  
    College Student Aid Commission[283]  
    Higher Education Loan Authority[284]  
    Public Broadcasting Division[288]  
    School Budget Review Committee[289]  
EGG COUNCIL, IOWA[301]  
ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]  
EXECUTIVE COUNCIL[361]  
FAIR BOARD[371]  
HUMAN RIGHTS DEPARTMENT[421]  
HUMAN SERVICES DEPARTMENT[441]  
INSPECTIONS AND APPEALS DEPARTMENT[481]  
    Employment Appeal Board[486]  
    Child Advocacy Board[489]  
    Racing and Gaming Commission[491]  
    State Public Defender[493]  
IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495]  
IOWA PUBLIC INFORMATION BOARD[497]  
LAW ENFORCEMENT ACADEMY[501]



LIVESTOCK HEALTH ADVISORY COUNCIL[521]  
MANAGEMENT DEPARTMENT[541]  
    Appeal Board, State[543]  
    City Finance Committee[545]  
    County Finance Committee[547]  
NATURAL RESOURCES DEPARTMENT[561]  
    Environmental Protection Commission[567]  
    Natural Resource Commission[571]  
PETROLEUM UNDERGROUND STORAGE TANK FUND BOARD, IOWA COMPREHENSIVE[591]  
PROPANE EDUCATION AND RESEARCH COUNCIL, IOWA[599]  
PUBLIC DEFENSE DEPARTMENT[601]  
HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]  
PUBLIC EMPLOYMENT RELATIONS BOARD[621]  
PUBLIC HEALTH DEPARTMENT[641]  
PUBLIC SAFETY DEPARTMENT[661]  
RECORDS COMMISSION[671]  
REGENTS BOARD[681]  
    Archaeologist[685]  
REVENUE DEPARTMENT[701]  
SECRETARY OF STATE[721]  
SHEEP AND WOOL PROMOTION BOARD, IOWA[741]  
COMMUNICATIONS NETWORK, IOWA[751]  
TRANSPORTATION DEPARTMENT[761]  
TREASURER OF STATE[781]  
TURKEY MARKETING COUNCIL, IOWA[787]  
VETERANS AFFAIRS, IOWA DEPARTMENT OF[801]  
VETERINARY MEDICINE BOARD[811]  
VOLUNTEER SERVICE, IOWA COMMISSION ON[817]  
VOTER REGISTRATION COMMISSION[821]  
WORKFORCE DEVELOPMENT DEPARTMENT[871]  
    Labor Services Division[875]  
    Workers' Compensation Division[876]  
    Workforce Development Board, State[877]

**RA 26-67****HUMAN SERVICES DEPARTMENT[441]****Regulatory Analysis**

Notice of Intended Action to be published: 441—Chapter 31  
“Civil Commitment Unit for Sexual Offenders”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 229A.15B

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 229A

*Public Hearing*

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

June 16, 2026

10 a.m.

Microsoft Teams

Meeting ID: 263 169 532 452 86

Passcode: mw3az6Y4

*Public Comment*

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

Victoria L. Daniels

Lucas State Office Building

321 East 12th Street

Des Moines, Iowa 50319

Phone: 515.829.6021

Email: [compliancerules@hhs.iowa.gov](mailto:compliancerules@hhs.iowa.gov)

*Purpose and Summary*

This proposed rulemaking outlines requirements for patients at the Civil Commitment Unit for Sexual Offenders (CCUSO). CCUSO provides a secure, long-term, and highly structured setting to treat sexually violent predators who have served their prison terms but who, in a separate civil trial, have been found likely to commit further violent sexual offenses.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of that review, the Department removed duplicative and outdated information and restrictive terms, where appropriate.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking, although funds are appropriated each year to maintain CCUSO.

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

The public will benefit from the structure imposed for CCUSO patients.

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

- **Quantitative description of impact:**

As of February 2026, an average of 183 patients are housed and treated at CCUSO. The patient population continues to grow. For every one patient discharged, another four are admitted. CCUSO cannot deny or delay any admission.

- **Qualitative description of impact:**

This proposed rulemaking removes language that is duplicative or outdated.

3. **Costs to the State:**

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

CCUSO's SFY 2026 operating costs are \$22,630,208.

- **Anticipated effect on State revenues:**

The proposed SFY 2027 proposed appropriation is status quo at \$22,624,208.

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

Rulemaking is required by Iowa Code section 229A.15B.

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

Not applicable.

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

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

Not applicable.

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

Not applicable.

*Small Business Impact*

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

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

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

This proposed rulemaking has no impact on small business.

*Text of Proposed Rulemaking*

ITEM 1. Rescind 441—Chapter 31 and adopt the following **new** chapter in lieu thereof:

CHAPTER 31  
CIVIL COMMITMENT UNIT FOR SEXUAL OFFENDERS

**441—31.1(229A) Definitions.**

“*Contraband*” means weapons; ammunition; tobacco; alcohol; drugs; money; altered authorized property; mood-altering plant materials or chemicals; obscene materials as defined in Iowa Code

section 728.1(5); explosives; materials that can be used in the manufacture of explosives; or materials advocating disruption of or injury to patients, employees, programs, or physical facilities. “Contraband” includes anything that is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. “Contraband” also includes anything determined to be banned from individual possession by published facility rules.

“*Facility*” means the civil commitment unit for sexual offenders (CCUSO).

“*Grievance*” means a written complaint by or on behalf of a patient that involves a rights or rule violation or unfairness to the patient.

“*Guardian*” means the person other than a parent of a child who has been appointed by the court to have custody of the person of the patient as provided under Iowa Code section 232.2(26) or 633.3(22).

“*Institutional superintendent*” means the person appointed as the administrator of CCUSO.

“*Patient*” means a person who has been committed to CCUSO under Iowa Code chapter 229A.

**441—31.2(229A) Visitation.** CCUSO will maintain policies and procedures for visitation for patients.

**441—31.3(229A) Grievances.** CCUSO will maintain policies and procedures for patients to file a grievance. A patient’s family or guardian may file a grievance on the patient’s behalf.

**441—31.4(229A) Photographing and recording patients.** CCUSO will utilize video surveillance for security and investigations. Photographing and video and audio recording of patients for any other purpose are subject to CCUSO’s policies and procedures for prior authorization.

**441—31.5(229A) Public media.** Photographs and video and audio recordings by public media inside the facility and of patients will be permitted only with the prior authorization of the institutional superintendent and of the patient or the patient’s guardian.

**31.5(1)** For the security or confidentiality of other patients, the institutional superintendent may limit the scope of what is photographed or recorded.

**31.5(2)** Public media representatives authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the patient and to preclude the exploitation or embarrassment of the patient.

**441—31.6(229A) Communication with patients.**

**31.6(1)** *Incoming telephone calls.* CCUSO does not allow patients to receive incoming telephone calls.

**31.6(2)** *Outgoing telephone calls.* CCUSO will maintain policies and procedures for patients to make outgoing telephone calls.

**31.6(3)** *Attorney contacts.* A patient’s attorney shall have the right to visit or have telephone contact with the patient at any reasonable time. The patient shall have the right to call the individual’s attorney during normal business hours and at other times with the consent of the attorney. The patient or the attorney shall be responsible for any costs associated with the call.

**31.6(4)** *Interviews.* Interviews of a patient by the news media or other outside persons or groups shall be permitted only with the prior consent of the patient or the patient’s guardian. Requests for interviews shall be made to the institutional superintendent.

**31.6(5)** *Mail and packages.* CCUSO will maintain policies and procedures for incoming and outgoing mail, including a policy that correspondence is not permitted between a patient and a patient’s victim, a registered sex offender, or another patient residing at CCUSO. Should mail or packages be rejected by the facility for any reason, such as containing contraband, being a security risk, or being counter-therapeutic, notice will be provided to the sender and the recipient via the CCUSO form Notice of Rejection of Mail within two business days.

**441—31.7(229A) Building and grounds.** The facility's building and grounds are not available for general public use.

**441—31.8(229A) Cost of care.** The facility will seek to recover the full cost or a portion of the cost of care from the patient or another responsible person. The cost of the patient's care will be determined for each fiscal year included in the length of stay using the average per diem cost multiplied by the total number of days of care.

**31.8(1) *Social security benefits.*** The facility will seek recovery from the patient when the patient receives a benefit pursuant to the Social Security Act as amended to August 1, 2026. In such case, the patient will be allowed to retain for personal use an amount equal to the personal allowance amount established by the Social Security Administration.

**31.8(2) *Other income.*** The facility will seek recovery from the patient when the patient has other income; a trust fund; individually owned real estate, stocks, or bonds; an individually owned savings account, checking account, or certificate of deposit; an individual retirement account; or proceeds from the disposal of real estate or other property.

**31.8(3) *Other person legally liable.*** The facility will seek recovery from a person who is legally liable for the support of the patient up to the amount of the person's legal liability. The facility will seek recovery from a person who is bound by contract to support the patient up to the amount of the contract. A person legally liable to support the patient does not include a political subdivision.

These rules are intended to implement Iowa Code section 229A.15B.

**RA 26-68****INSPECTIONS AND APPEALS DEPARTMENT[481]****Regulatory Analysis**

Notice of Intended Action to be published: 481—Chapter 100  
“General Provisions for Social and Charitable Gambling”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 99B.2

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 99B and 2026 Iowa Acts, House File 2506

*Public Hearing*

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

June 17, 2026  
9 a.m.

Ledges Conference Room  
6200 Park Avenue, Suite 100  
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

*Public Comment*

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

Amy Oetken  
Department of Inspections, Appeals, and Licensing  
6200 Park Avenue, Suite 100  
Des Moines, Iowa 50321  
Phone: 515.672.4929  
Email: [amy.oetken@dia.iowa.gov](mailto:amy.oetken@dia.iowa.gov)

*Purpose and Summary*

This rulemaking implements 2026 Iowa Acts, House File 2506. This allows for organizations conducting social and charitable gambling events to notify a prize winner within one year of the prize being awarded.

*Analysis of Impact*

1. **Persons affected by the proposed rulemaking:**
  - **Classes of persons that will bear the costs of the proposed rulemaking:**  
There are no anticipated costs related to this rulemaking.
  - **Classes of persons that will benefit from the proposed rulemaking:**  
The members of the industry will benefit from having more raffle options.
2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**
  - **Quantitative description of impact:**

The members of the industry will have more options when distributing prizes.

- **Qualitative description of impact:**

The proposed rulemaking allows more flexibility when distributing prizes to ensure the maximum number of people have the ability to win a prize.

3. **Costs to the State:**

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

There is no anticipated effect on agency costs.

- **Anticipated effect on State revenues:**

There is no anticipated effect on State revenues.

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

There are no specific financial costs to implement or enforce this proposed rulemaking outside of any costs associated with the Department's statutory duties identified.

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

There are no less costly or intrusive methods for achieving the purpose of the proposed rulemaking.

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

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

See response to question 5 above.

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

See response to question 5 above.

*Small Business Impact*

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

Iowa Code chapter 99B does not allow for exemptions or different standards for small businesses or organizations.

*Text of Proposed Rulemaking*

ITEM 1. Rescind subrule 100.10(1) and adopt the following **new** subrule in lieu thereof:

**100.10(1)** A copy of the rules for a raffle shall be available upon request and include the following:

- a. Methods of awarding a prize, including the date the prize is won;
- b. Prices to play, including discounts; and

c. Whether a sufficient number of entries must be sold in order for the raffle to occur, or if an alternate prize is offered when sales of entries are insufficient.

ITEM 2. Rescind subrule 100.16(4) and adopt the following **new** subrule in lieu thereof:

**100.16(4) *Winners.*** The drawing of the winning entry shall be done in a manner that allows the purchasers to observe the drawing.

a. The raffle shall clearly describe the date the prize will be considered to be won. If no specific winning date is specified, the prize will be considered to be won on the date of the drawing.

b. The date by which the prize shall be claimed will be no fewer than 14 days following the notification of the winner.

c. Notification will be considered to be as soon as practical so long as it is within one year of the prize being awarded.

d. If the prize is not claimed, the licensed QO may do one of the following:

(1) Continue to draw until a winner claims the prize. Each drawing will allow the time period specified in paragraph 100.16(4) “b” for claiming the prize.

(2) Donate the unclaimed prize to another QO to be used for an educational, civic, public, charitable, patriotic, or religious use.



**RA 26-69****INSPECTIONS AND APPEALS DEPARTMENT[481]****Regulatory Analysis**

Notice of Intended Action to be published: 481—Chapter 2050  
“Appraisal Management Companies”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 543E

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 17A and 543E and Title XI, Section 1473, of the Dodd-Frank Wall Street Reform and Consumer Protection Act

*Public Hearing*

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

June 16, 2026  
10 to 10:30 a.m.

6200 Park Avenue, Suite 100  
Des Moines, Iowa

Virtual participation information will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

*Public Comment*

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

Kimberly Gleason, Board Administrator  
Department of Inspections, Appeals, and Licensing  
6200 Park Avenue, Suite 100  
Des Moines, Iowa 50321  
Phone: 515.725.8145  
Email: [kimberly.gleason@dia.iowa.gov](mailto:kimberly.gleason@dia.iowa.gov)

*Purpose and Summary*

Proposed Chapter 2050 establishes the requirements for appraisal management companies (AMCs) to obtain registration in the State of Iowa, including initial/preregistration, renewals, reinstatement, fees, registrant records, investigations, complaints, disciplinary action, and the National Registry maintained by the Appraisal Subcommittee (ASC).

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

There are costs to the registrant in terms of fees for registration. The fee for initial registration is \$750, with a \$250 application fee. The yearly renewal fee (recertification) is \$750, with an additional \$25 per AMC panel member that engaged to perform one or more appraisals in the State during a set time period prior to the renewal. The \$25 per panel member is forwarded to the ASC National Registry. The following chart reflects the initial registration fee followed by the one-year renewal for surrounding states.

|               |                 |                 |             |                 |               |
|---------------|-----------------|-----------------|-------------|-----------------|---------------|
| South Dakota  | Minnesota       | Illinois        | Missouri    | Nebraska        | Kansas        |
| \$1,000/\$750 | \$5,000/\$2,500 | \$2,500/\$2,000 | \$350/\$350 | \$2,350/\$1,500 | \$1,500/\$900 |

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

The public and professionals benefit from the proposed rulemaking. Establishing minimum requirements ensures that the registrants are competent to provide services in Iowa. Section 1473 of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) dictates the minimum requirements in the registration and supervision of AMCs. An AMC that oversees a panel of more than 15 appraisers in a single state or 25 or more appraisers nationally in a year must register with the state. Qualifying AMCs that wish to engage in federally regulated transactions must hold a registration in the state.

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

- **Quantitative description of impact:**

There are no costs to the public. AMCs are registered providers regulated in accordance with federal and State law.

- **Qualitative description of impact:**

The primary impact of this proposed rulemaking is to the Iowans who utilize AMC services and are protected by the rules established to become registered. In order to regulate and register AMCs as directed in statute, base standards for registration are critical pursuant to federal requirements.

**3. Costs to the State:**

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

Costs to the agency are for the staff time needed to manage activities, which include managing applications for initial registration and renewals and maintaining the appraisal subcommittee national registry. The program utilizes approximately less than 1.0 full-time equivalent (FTE) position to process license applications and answer applicant and registrant questions. Staff salaries to support the work of the program are covered by the Licensing and Regulation Fund. Licensing fees go into the fund to cover the cost of the programs regulations.

- **Anticipated effect on State revenues:**

Costs associated with implementing this rulemaking are paid by registrants, not the State. This rulemaking has no anticipated impact on State revenues. Staff salaries to support the work of the program are covered by the Licensing and Regulation Fund. Registration fees go to the fund to cover the operations of the regulated professional licensing boards.

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

Current requirements ensure public safety and ensure competency for services provided to Iowans. Due to federal requirements, inaction is not advised.

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

The current initial registration requirement ensures public safety and ensures competency for services provided to Iowans. Iowa's registration and renewal fees tend to be the lowest in the 56 states and territories.

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

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

Staff held conversations with the ASC regarding this chapter. The requirements set by the State of Iowa are directed by the federal government. No alternate methods were considered.

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

An alternative to registration has not been identified. Maintaining federal requirements for registered AMCs is critical to Iowans and the mortgage industry.

*Small Business Impact*

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

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

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

The rulemaking is meant to ensure public safety in terms of registration of AMCs. To exempt small businesses from adhering to this rulemaking would jeopardize any member of the public who sought services from those small businesses. The risk to the public is greater than the potential harm or cost to small business.

*Text of Proposed Rulemaking*

ITEM 1. Rescind 481—Chapter 2050 and adopt the following **new** chapter in lieu thereof:

CHAPTER 2050  
APPRAISAL MANAGEMENT COMPANIES

**481—2050.1(17A,543E) Definitions.** For the purposes of this chapter, the definitions in Iowa Code chapter 543E apply. In addition, unless the context dictates otherwise, the following definitions apply:

“*Owner*” means a person who owns or has the power to vote more than 10 percent of the shares of an appraisal management company.

“*Ownership*” means being an owner or otherwise having the power to vote more than 10 percent of the shares of an appraisal management company.

“*Registrant*” means a person who is registered as an appraisal management company in this state.

**481—2050.2(17A,543E) Application for registration.**

**2050.2(1)** An application for registration to operate an appraisal management company in Iowa will be submitted to the administrator through the program's online system. All information requested in the application will be provided on or with the application, including but not limited to any and all information obligated by Iowa Code section 543E.8(2). The administrator may consider an application withdrawn if the application does not contain all of the information requested and the missing information is not submitted within 30 days after the administrator requests the missing information.

**2050.2(2)** Appraiser panel. The application will include a list of all certified appraisers who are independent contractors and are currently on the applicant's appraiser panel and will also include any additional certified appraisers who are independent contractors and who in the 12 months immediately preceding submission of the application have performed appraisals, for the applicant or for persons who have ordered appraisals through the applicant, for covered transactions or for secondary mortgage market participants in connection with covered transactions in which the dwelling is located in this state. The application will include the name, the certification number, the date the appraiser joined the panel, and the date the appraiser left the panel, if applicable, for each appraiser included on the

applicant's appraiser panel. The applicant's appraiser panel will include all appraisers the applicant has engaged to perform one or more appraisals for or in connection with a covered transaction or for a secondary mortgage market participant in connection with a covered transaction in this state and all appraisers the applicant has accepted for future consideration for such appraisal assignments.

**2050.2(3)** All owners and controlling persons of the applicant will submit to a background investigation, as determined by the administrator.

**2050.2(4)** The applicant will submit an application fee and initial registration fee in the amounts provided in subrule 2050.8(5), as well as the fee for registration on the appraisal management company national registry maintained by the appraisal subcommittee as specified in subrule 2050.8(5). The applicant will be refunded the initial registration fee and the appraisal management company national registry fee if the application is denied.

**2050.2(5)** If any information material to the application changes after the applicant files the initial application but before the administrator approves or denies the application, the applicant will provide updated information to the administrator in writing within ten calendar days of the change. The administrator may deny the application when such a material change in information has occurred and the applicant has failed to provide updated information within the prescribed time frame.

**2050.2(6)** An applicant for registration to operate an appraisal management company in Iowa will file with the administrator a \$25,000 surety bond in compliance with the provisions of Iowa Code section 543E.19.

**2050.2(7)** A registration will lapse on the next succeeding December 31 after it is issued, but a registration granted on or after November 1 and before December 31 will not lapse until December 31 of the following year. For example, a registration granted on November 17, 2017, would not expire until December 31, 2018. An applicant whose registration is granted on or after November 1 and before December 31 may be needed, as determined by the appraisal subcommittee, to pay the fee for registration on the appraisal management company national registry in full for both calendar years. For example, while a registration granted on November 17, 2017, would not lapse until December 31, 2018, the registrant may be obligated to pay the national registry fee in full for 2017 and 2018.

**481—2050.3(17A,543E) Grounds for denial of a registration.** The administrator may deny an application for registration to operate an appraisal management company, or issue a registration subject to conditions, for any of the reasons that follow.

**2050.3(1)** This state or another state or jurisdiction has canceled, revoked, denied, suspended, or refused to renew the applicant's registration to operate an appraisal management company or has denied, suspended, or refused to renew a similar registration under this state's or the other state's or jurisdiction's law. An agreement made between a person and this state or another state or jurisdiction not to operate as an appraisal management company may be considered a denial of that person's registration to operate an appraisal management company in this state or the other state or jurisdiction.

**2050.3(2)** An owner or controlling person of the applicant has been barred, removed, or prohibited from owning or serving as the controlling person of an appraisal management company, or from serving in any capacity in a financial institution by any state or federal regulatory agency, including but not limited to the Office of the Comptroller of the Currency, the Federal Deposit Insurance Corporation (FDIC), the Board of Governors of the Federal Reserve System, or the U.S. Department of Housing and Urban Development.

**2050.3(3)** An owner or controlling person of the applicant is or was the owner or controlling person of another appraisal management company in another state or jurisdiction, if such other state or jurisdiction has canceled, revoked, denied, suspended, or refused to renew the registration or application for registration of such other appraisal management company under this state's or the other state's or jurisdiction's law. An agreement made between a person and this state or another state or jurisdiction not to operate as the owner or controlling person of an appraisal management company may be considered a denial of that person's application to serve as the owner or controlling person of an appraisal management company in this state or the other state or jurisdiction.

**2050.3(4)** An owner or controlling person of the applicant has been convicted of forgery, embezzlement, obtaining money under false pretenses, theft, extortion, conspiracy to defraud, tax evasion, or another similar offense, in a court of competent jurisdiction in this state or in any other state, territory, or district of the United States or in any foreign jurisdiction. For the purposes of this subrule, “convicted of” includes a guilty plea, deferred judgment, deferred sentence, or other similar finding of guilt by a court of competent jurisdiction.

**2050.3(5)** The applicant, or an owner or controlling person of the applicant, has made a false submission of material fact on an application for registration or has been otherwise implicated in the submission of a false application.

**2050.3(6)** An owner or controlling person of the applicant has demonstrated a lack of moral character in a manner that the administrator reasonably believes will impair the ability of the owner or controlling person to operate an appraisal management company in full compliance with the public interest and state policies described in Iowa Code chapter 543E.

**2050.3(7)** For any reason listed in Iowa Code section 543E.17(1).

**2050.3(8)** The applicant has failed to include all of the information in the application or has failed to pay any fee obligated under Iowa Code chapter 543E or this chapter.

#### **481—2050.4(17A,543E) Renewal of registration.**

**2050.4(1)** To remain registered to operate an appraisal management company in Iowa, a registrant will renew a registration before the date the registration lapses. Lapsed registrant obligations are outlined in Iowa Code section 543E.9(5).

**2050.4(2)** An application to renew a registration will be submitted to the administrator, through the program’s online system, no earlier than November 1 and no later than December 1 of the year for which the registration is valid. For example, for a registration that will lapse on December 31, 2025, an application for renewal will be submitted by December 1, 2025. All requested information, including any material change to information contained in the original application, will be provided to the administrator. Applications for renewal of a registration will be accompanied by a fee as specified in subrule 2050.8(5). The administrator may also assess late fees as specified in subrule 2050.8(5) for applications submitted after December 1.

**2050.4(3)** The administrator will grant an application to renew a registration if:

- a.* The administrator receives the application and the appropriate renewal fee by December 1, or the administrator receives the application after December 1 but before January 1 and it is accompanied by the appropriate renewal fee and the appropriate late fee;
- b.* The application is fully completed and includes all necessary information; and
- c.* The application does not reveal grounds that would be sufficient to deny initial registration, or issue a registration subject to conditions, pursuant to rule 481—2050.4(17A,543E).

#### **481—2050.5(17A,543E) Reinstatement of lapsed registration.**

**2050.5(1)** The registration of an appraisal management company that has lapsed for failure to satisfy the minimum standards for renewal may be reinstated if the registrant meets the following:

- a.* The application for reinstatement is submitted between January 1 and February 28 of the year immediately following the year the registration lapsed.
- b.* All minimum obligations for renewal of registration for the year in which the registration lapsed are satisfied prior to submission of the application for reinstatement. The registrant seeking to reinstate a registration will submit all information requested to renew a registration pursuant to rule 481—2050.4(17A,543E).
- c.* The registrant pays a reinstatement fee as specified in subrule 2050.8(5), in addition to the renewal fee, and any late charges.

**2050.5(2)** An appraisal management company whose registration has lapsed and who fails to meet the obligations for reinstatement specified in this rule will apply for a new registration and meet the obligations in effect at that time for a new registration.

**481—2050.6(17A,543E) Changes in the registrant's name, location, or ownership.**

**2050.6(1)** A registrant wishing to change the principal location of an appraisal management company will notify the administrator through the program's online system, within 15 days of making the change. The notice will include proof that the registrant has either obtained a new bond or amended the existing mandatory bond to reflect the new location. The registrant will submit a fee as specified in subrule 2050.8(5) in association with the change.

**2050.6(2)** Registrants will notify the administrator no later than 15 days following a change in name and will submit to the administrator a fee as specified in subrule 2050.8(5).

**2050.6(3)** The prior written approval of the administrator is necessary whenever a change in ownership of a registrant is proposed. When a change in ownership of a registrant is proposed, the party that will assume ownership of the registrant will give notice to the administrator through the program's online system, at least 30 days before the proposed change will take effect. The party that will assume ownership of the registrant will furnish the administrator through the program's online system, with the same information of initial applicants for registration, along with a fee as specified in subrule 2050.8(5). The administrator will approve or deny the request in accordance with the provisions of rule 481—2050.3(17A,543E).

**2050.6(4)** The prior written approval of the administrator is necessary whenever a change of the designated controlling person of a registrant is proposed. When change of the designated controlling person of a registrant is proposed, the party that will become the designated controlling person of the registrant will give notice to the administrator through the program's online system at least 30 days before the proposed change will take effect. The party that will become the designated controlling person of the registrant will furnish the administrator through the NMLS, or as otherwise prescribed by the administrator, with the same information requested of initial applicants for designation as a controlling person, along with the appropriate fee. The administrator will approve or deny the request in accordance with the provisions of rule 481—2050.3(17A,543E).

**2050.6(5)** Failure to notify the administrator within the prescribed time as obligated by this rule may subject the registrant to disciplinary action. However, in the event the death, incapacity, or unexpected resignation of a designated controlling person, or a similar circumstance, makes it impossible for a registrant to provide 30 days' advance notice, no disciplinary action will be taken if the party that will become the designated controlling person of the registrant provides the notice described in subrule 2050.6(4) promptly and no later than 10 days after learning that a new controlling person will be designated.

**481—2050.7(17A,543E) Notice of significant events.** A registrant will notify the administrator immediately and in writing within 15 calendar days of the occurrence of any of the following events:

**2050.7(1)** The registrant or any of the registrant's officers, directors, owners, or affiliates file for bankruptcy protection or commence reorganization proceedings.

**2050.7(2)** A prosecuting authority files criminal charges against the registrant or any of a registrant's officers, directors, owners, or affiliates.

**2050.7(3)** Another state or jurisdiction institutes registration denial, cease and desist, suspension or revocation procedures, or other regulatory action against the registrant or any of the registrant's officers, directors, owners, or affiliates.

**481—2050.8(17A,543E) Fees.**

**2050.8(1)** *Examination or investigation fees.* A registrant will pay an investigation or examination fee as described in Iowa Code section 543E.10(1).

**2050.8(2)** *Examination or investigation late fees.* A registrant will pay the administrator the total charge for an examination or investigation within 30 days after the administrator has requested payment. If a registrant fails to pay an examination or investigation fee by the due date, the administrator may assess an additional penalty as identified in subrule 2050.8(5) for each day the fee is overdue.

**2050.8(3)** *Late fees for failing to respond.* In the process of administering this chapter, the administrator may obligate a person to provide responses to formal orders, examinations, or complaint inquiries. If a person fails to respond within 30 days of the request, the administrator may assess a fee as specified in subrule 2050.8(5).

**2050.8(4)** Reserved.

**2050.8(5)** *Fees.*

|                                                                                                                   |                                                            |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| Application for registration fee                                                                                  | \$250                                                      |
| Registration fee (initial) (not applicable to preregistration)                                                    | \$750                                                      |
| Registration fee (annual renewal)                                                                                 | \$750                                                      |
| Background investigation fee (if requested)                                                                       | \$51                                                       |
| Appraisal management company national registry fee<br>(not applicable to preregistration)                         | As determined by the<br>appraisal subcommittee             |
| Fee for late submission of application for renewal                                                                | \$50                                                       |
| Fee to reinstate a lapsed registration                                                                            | \$250                                                      |
| Reissuance or replacement of a lost, destroyed, or stolen registration                                            | \$25                                                       |
| Fee for change of principal location                                                                              | \$25                                                       |
| Fee for change of name                                                                                            | \$25                                                       |
| Fee for change of ownership                                                                                       | \$150                                                      |
| Fee for change of controlling person                                                                              | \$150                                                      |
| Fee for late payment of examination or investigation fees                                                         | 5 percent of amount due per day<br>beyond 30 days past due |
| Fee for late response to examination request                                                                      | \$10 per day beyond 30 days past due                       |
| Conversion fee for preregistered persons (applicable only when<br>converting a preregistration to a registration) | \$150                                                      |
| Dishonored check fee                                                                                              | \$30                                                       |
| Examination or investigation fee                                                                                  | \$100 per hour                                             |
| Mailing list fee                                                                                                  | \$30                                                       |
| Fee for letter of good standing                                                                                   | \$25                                                       |

**481—2050.9(17A,543E) Registrant records.**

**2050.9(1)** *General record obligations.* The following obligations apply to all records a registrant is obligated to keep pursuant to Iowa Code section 543E.13 and this chapter:

- a. The registrant may keep records as a hard copy or in an electronic equivalent.
- b. The registrant will maintain all books and records in good order and will produce books and records for the administrator upon request. Failure to produce such books and records within 30 days of the administrator's request may be grounds for disciplinary action against the registrant.
- c. The obligation to maintain records continues even after the registrant ceases business operations in Iowa and turns in or surrenders its registration. The owners and directors of the registrant are responsible for ensuring that this obligation is met for the period listed under Iowa Code section 543E.13 and this chapter.
- d. The registrant will keep all records for at least five years from the date the record was created, unless a longer retention period is mandated by statute.

**2050.9(2)** *Required records.* A registrant operating an appraisal management company will keep, and be able to retrieve or access from its principal place of business, an appraisal request and assignment log, a true and complete copy of each appraisal performed, a payment log, applications for registration, a dispute resolution policy, and certain corporate records.

- a. *Appraisal request and assignment log.* A registrant will maintain a log of all appraisal services requested, including those requests for service that the registrant does not fulfill. A record of the appraiser assigned to each request for appraisal services accepted by the registrant will also be kept. The record will include a description of the assignment, the certification or registration number

of the assigned appraiser, the certification possessed by the assigned appraiser, and the expiration date of the appraiser's certification.

*b. Appraisal files.* For each appraisal service assigned by a registrant to an appraiser, the registrant will keep a record of the award or engagement letter giving the appraisal assignment to the appraiser; the assigned appraiser's acceptance of the assignment; all material communications between the registrant, the assigned appraiser, and the service requestor regarding a consumer credit transaction secured by the principal dwelling of an Iowa consumer, or the securitization thereof; and the appraisal report created by the assigned appraiser.

*c. Payment log.* A record will be kept of all payments made by a registrant in association with the provision of appraisal services and will include the date the payment was made, the amount paid, the appraisal services for which payment was made, and the date on which the appraiser provided the results of the completed appraisal service to the registrant.

*d. Dispute resolution policy.* A registrant will maintain a copy of a dispute resolution policy for appraisers who request a review of a decision made by the registrant. The dispute resolution policy will provide for a written response to the appraiser's request for review, a written statement of the outcome of the dispute resolution process, and a copy of all relevant documents to the appraiser upon request. The dispute resolution policy will provide for external review of the decision in question or internal review of the decision in question by an officer or employee of a registrant who holds a higher position than the individual who made the decision in question.

*e. Corporate records.* A registrant will maintain lists of all owners, directors, officers, and employees, as well as the minutes from meetings of the registrant's board of directors if the registrant's corporate structure includes a board of directors.

**2050.9(3) General business records.** In addition to the required records, a registrant will keep the following general business records for at least five years from the date the record was created:

*a.* All checkbooks, check registers, bank statements, deposit slips, withdrawal slips, and canceled checks (or copies thereof) relating to the registrant's operation of an appraisal management company.

*b.* Complete records (including invoices and supporting documentation) for all expenses and fees paid in connection with each appraisal, including a record of the date and amount of all such payments actually made in connection with each appraisal.

*c.* Copies of all federal tax withholding forms, reports of income for federal taxation, and evidence of payments to all employees, independent contractors, and others compensated by a registrant in connection with the operation of an appraisal management company.

*d.* All correspondence and other records relating to the maintenance of any surety bond obligated by Iowa Code chapter 543E.

*e.* Copies of all reports of audits, examinations, inspections, reviews, investigations, or other similar functions performed by any third party, including but not limited to the administrator or any other regulatory or supervisory authority.

**2050.9(4) Disposal of records.** If a registrant or former registrant disposes of records at the end of the retention period, the registrant or former registrant will dispose of the records in a reasonable manner that safeguards any identification information, as defined in Iowa Code section 715A.8(1) "a." The owners and directors of registrants and former registrants are responsible for ensuring that this obligation is met.

#### **481—2050.10(17A,543E) Examinations, investigations, and complaints.**

**2050.10(1)** The administrator may, at any time and as often as the administrator deems necessary, examine a registrant's books, accounts, records, and files and investigate a registrant to assess potential violations of applicable appraisal-related laws, regulations, rules, or orders.

**2050.10(2)** The administrator may investigate complaints about, or alleged violations committed by, any registrant.

**2050.10(3)** The following will constitute a complaint or alleged violation:



- a.* A written complaint received from a consumer, member of the public, employee, business affiliate, or other governmental agency through the program's online system.
- b.* Notice to the administrator from any source that the registrant, or any owner or controlling person thereof, has been the subject of disciplinary proceedings in another jurisdiction.
- c.* Notice to the administrator from any source that any owner or controlling person of the registrant has been convicted of forgery, embezzlement, obtaining money under false pretenses, extortion, conspiracy to defraud, or other similar offense, in a court of competent jurisdiction in this state or in any other state, territory, or district of the United States, or in any foreign jurisdiction.

**481—2050.11(17A,543E) Disciplinary action.**

**2050.11(1)** The administrator has the authority pursuant to Iowa Code chapters 543E and 17A to impose discipline for violations of Iowa Code chapter 543E and this chapter.

**2050.11(2)** Grounds for discipline. The administrator may impose any of the disciplinary sanctions set out in Iowa Code section 543E.17(1) when the administrator finds any of the following:

- a.* The registrant, or an owner or controlling person thereof, has violated a provision of Iowa Code chapter 543E or this chapter.
- b.* The registrant, or an owner or controlling person thereof, fails to fully cooperate with an examination or investigation, including failing to respond to an inquiry from the administrator within 30 calendar days of the date the administrator mails a written communication directed to the registrant's last-known address on file with the administrator.
- c.* The registrant, or an owner or controlling person thereof, has engaged in any conduct that subverts or attempts to subvert an examination or investigation by the administrator.
- d.* The registrant continues to operate an appraisal management company without an active and current registration.
- e.* The registrant fails to timely notify the administrator of the occurrence of any of the significant events set forth in rule 481—2050.7(17A,543E).
- f.* The registrant fails to notify the administrator of a change in ownership, controlling person, name, or principal place of business.
- g.* Another state or jurisdiction has denied, suspended, revoked, or refused to renew the registrant's registration or authorization to operate an appraisal management company under the other state's or jurisdiction's law.
- h.* The registrant fails to create and maintain complete and accurate records as obligated by state or federal law, regulation, or rule.
- i.* The registrant, or an owner or controlling person thereof, has violated an order of the administrator.
- j.* The registrant has abandoned its place of business for 60 or more days.
- k.* The registrant fails to pay any fee obligated by Iowa Code chapter 543E or this chapter or to maintain a bond obligated by Iowa Code chapter 543E.
- l.* A fact or condition exists that, had it existed at the time of the original application for registration, would have warranted the administrator to refuse to issue the original registration.

**2050.11(3)** A registrant may surrender a registration by delivering to the administrator a written notice of surrender.

**481—2050.12(17A,543E) Appraisal management company national registry maintained by the appraisal subcommittee.** The administrator will transmit to the appraisal subcommittee information and fees as necessary for inclusion on the appraisal management company national registry.

**2050.12(1)** *Registered appraisal management companies.* The administrator will transmit to the appraisal subcommittee all information regarding registered appraisal management companies required for inclusion on the appraisal management company national registry, including but not limited to a roster of appraisal management companies registered in this state and records relating to any disciplinary action taken against a registrant.

**2050.12(2)** *Federally regulated appraisal management companies.* The administrator will collect from a federally regulated appraisal management company all fees obligated for registration on the appraisal management company national registry maintained by the appraisal subcommittee. A federally regulated appraisal management company will also pay all fees associated with the administration of this rule. The administrator will collect from a federally regulated appraisal management company the following information necessary for the fulfillment of this obligation: the name, address, and telephone number of the company; the national registry identification number and tax identification number of the company; the start date of the company's registration on the appraisal management company national registry; the name of and contact information for a contact person for the company; and any other information as prescribed by the administrator.

**481—2050.13(17A,543E) Preregistration.**

**2050.13(1)** A person who is not obligated to register as an appraisal management company because its appraiser panel does not meet or exceed the size obligations specified in Iowa Code section 543E.3(1) may apply to the administrator for preregistration as an appraisal management company. If the administrator approves the application, the applicant will receive a preliminary notice indicating that the administrator intends to approve the applicant for registration as an appraisal management company, based on the information submitted, as soon as the appraiser panel that the applicant oversees meets or exceeds the statutory size obligations. The administrator's preliminary intent to approve registration will remain subject to change in the event that the administrator receives additional information indicating that registration should be denied.

**2050.13(2)** An applicant seeking preregistration as an appraisal management company will follow the application procedures prescribed in rule 481—2050.2(17A,543E), including providing all necessary information. The applicant will indicate that the applicant is applying for preregistration as an appraisal management company. The applicant will submit the application fee obligated by rule 481—2050.2(17A,543E), but an applicant under this provision need not submit the initial registration fee or the fee obligated by the appraisal management company national registry. The administrator will approve or deny the application for preregistration based on the criteria enumerated in rule 481—2050.3(17A,543E). Even if the administrator approves the application for preregistration, the applicant will not be registered on the appraisal management company national registry.

**2050.13(3)** A person who has received preregistration as an appraisal management company will apply for registration as an appraisal management company at least 30 days before the appraisal panel that the preregistered person oversees meets or exceeds the size obligations specified in Iowa Code section 543E.3(1). The applicant will submit a conversion application to the administrator, specifying the new size of the applicant's appraiser panel as obligated by subrule 2050.2(2), updating all information as necessary, and including any other information as prescribed by the administrator. The applicant will also submit a conversion fee, the initial registration fee, and the fee obligated by the appraisal management company national registry as specified in subrule 2050.8(5).

**2050.13(4)** The administrator will approve the application for registration unless additional information submitted by the applicant, or otherwise received by the administrator, indicates that the applicant is ineligible for registration based on the criteria enumerated in rule 481—2050.3(17A,543E). After the administrator approves registration, the applicant will be registered on the appraisal management company national registry and will comply with the provisions of Iowa Code chapter 543E and this chapter.

These rules are intended to implement Iowa Code chapters 17A and 543E.

**RA 26-70****PUBLIC HEALTH DEPARTMENT[641]****Regulatory Analysis**

Notice of Intended Action to be published: 641—Chapter 131  
“Emergency Medical Services—Certification, Renewal, and Continuing Education”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A, 147D, and 272C.4

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147A and 147D and section 272C.4

*Public Hearing*

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

June 16, 2026  
10 a.m.

Microsoft Teams  
Meeting ID: 263 169 532 452 86  
Passcode: mw3az6Y4

*Public Comment*

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

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

*Purpose and Summary*

This proposed rulemaking updates and streamlines Iowa’s certification, renewal, and continuing education requirements for Iowa emergency medical services (EMS) workers. Key changes include modernizing the continuing education hours (CEHs) structure, reactivation pathways, and background check process, as well as an updated scope of practice. These proposed amendments will help ensure compliance with national EMS standards, reduce administrative complexity, and reinforce consistent statewide practice expectations. Adoption of updated rules will support a more competent and better-prepared EMS workforce.

Specifically, this proposed rulemaking:

- Modernizes the continuing education structure by adding pediatric CEH requirements and allowing half-hour CEHs.
- Updates the background check process by reflecting the use of digital fingerprints and removing the outdated card-based system.
- Updates references to the Iowa Emergency Medical Care Provider Scope of Practice for EMS workers to the most current version.
- Restructures reactivation pathways, eliminating the 25- to 48-month reactivation option and redirecting impacted individuals to the National Registry of Emergency Medical Technicians (NREMT) knowledge assessment for reactivation.

- Updates the fee for returned payments from \$15 to \$40 to align with the ongoing Department of Inspections, Appeals, and Licensing (DIAL) alignment initiative.
- Updates the continuing education audit documentation deadlines from 45 days to 30 days to align with the ongoing DIAL alignment initiative.
- Updates language pertaining to certification denial or sanctions based upon feedback received from an administrative law judge regarding fraud.

#### *Analysis of Impact*

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

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

There are no costs associated with this proposed rulemaking beyond the updated returned check fee. In that regard, individuals applying for EMS credentials who submit checks for which there are insufficient funds will be subject to an increased fee.

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

Iowans will benefit from updated rules that will support a more competent and better-prepared EMS workforce.

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

###### **• Quantitative description of impact:**

As of April 2026, there were 10,746 EMS providers serving in Iowa. There are approximately 600 applicants per year.

###### **• Qualitative description of impact:**

Iowans will benefit from updated rules that will support a more competent and better-prepared EMS workforce.

##### **3. Costs to the State:**

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

The Department incurs personnel and other administrative costs associated with the program outlined in this proposed rulemaking.

###### **• Anticipated effect on State revenues:**

This proposed rulemaking has no impact on State revenues. Any fees associated with the program go to support the ongoing administration of the program.

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

Rulemaking is appropriate to maintain high standards for Iowa's EMS provider network.

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

Not applicable.

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

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

Not applicable.

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

Not applicable.

#### *Small Business Impact*

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

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

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

This proposed rulemaking has no impact on small business.

*Text of Proposed Rulemaking*

ITEM 1. Amend rule **641—131.1(147A,147D,272C)**, definitions of “CEH” and “Core continuing education,” as follows:

“*CEH*” means continuing education hour, which is based upon ~~a minimum of 50 minutes of training per hour. Fifty minutes equals one CEH, and 30 minutes equals one-half CEH.~~

“*Core continuing education*” means education obtained during a certification period to renew certification. Core continuing education will have an assigned sponsor number from CAPCE, an authorized EMS training program, ~~the board of nursing, the board of medicine or the department.~~

ITEM 2. Amend subrule 131.2(1) as follows:

**131.2(1)** An individual who has successfully completed the training program requirements at the EMR, EMT, AEMT or paramedic level and has a valid certification with NREMT shall submit the following to the department for initial Iowa emergency medical care provider certification:

- a. A completed EMS certification application.
- b. An NREMT active certification number.
- c. Payment of the initial application fee.
- d. ~~Two completed fingerprint cards for background checks.~~ A completed background check.
- e. ~~Payment of the background check fee.~~

ITEM 3. Amend subrule 131.4(2) as follows:

**131.4(2)** *Scope of practice.*

- a. No change.
- b. The Iowa Emergency Medical Care Provider Scope of Practice (~~September 2019~~) as amended to September 1, 2026, is hereby incorporated and adopted by reference for emergency medical care providers. For any differences that may occur between the scope of practice adopted by reference and these rules, the rules prevail. The Iowa Emergency Medical Care Provider Scope of Practice as amended to September 1, 2026, is available on the department's website.

~~e. The Iowa Emergency Medical Care Provider Scope of Practice (September 2019) is available on the department's website.~~

~~d. c.~~ The department may grant a waiver for changes to the scope of practice that have not yet been adopted by reference in these rules pursuant to 441—Chapter 6.

ITEM 4. Amend subrule 131.5(4) as follows:

**131.5(4)** *Reactivation of an inactive certification.*

- a. *Certification inactive up to 24 months.* An emergency medical care provider may apply to reactivate an inactive certification up to 24 months after the certification became inactive.

(1) No change.

(2) If the department approves the application, the individual must submit ~~an audit report form with 36~~ core continuing education hours ~~prorated per lapsed year by core topic area~~ based upon

the table in paragraph 131.5(7)“a” for the level of EMS certification requested for reactivation, a completed background check, and the reactivation fee. The core CEHs and the background check shall be completed after the department receives and approves the reactivation application.

(3) No change.

(4) An emergency medical care provider who fails to complete the reactivation process within 12 months from the date of application approval ~~must reapply for reactivation of the inactive certification will not be eligible for reactivation.~~

~~b. Certification inactive from 25 months to 48 months. An emergency medical care provider may apply to reactivate an inactive certification that has been inactive for 25 months but no more than 48 months.~~

~~(1) An individual will submit to the department an EMS certification reactivation application, which is available from the department upon request.~~

~~(2) If the department approves the application, the individual must submit documentation of successful completion of an approved EMS refresher course that includes successful completion of department or NREMT testing requirements. In addition, the individual must:~~

~~1. Complete fingerprint requirements.~~

~~2. Submit reactivation and background check fees.~~

~~3. Upon receipt and approval of the items required in subparagraphs 131.5(4)“b”(1) and (2), the department may issue a new certification.~~

~~4. An emergency medical care provider who fails to complete the reactivation process within 12 months from the date of application approval must reapply for reactivation of the inactive certification.~~

~~e. b. Certification inactive for more than 48 24 months. An emergency medical care provider may not cannot apply to reactivate a certification that has been inactive for more than 48 24 months. An emergency medical care provider who has been inactive for more than 24 months may complete the NREMT reentry requirements and apply for certification in accordance with subrule 131.2(1).~~

ITEM 5. Amend subrule 131.5(6) as follows:

**131.5(6) Fees.** The nonrefundable fees are as follows:

a. to g. No change.

h. Returned payment due to insufficient funds: \$15 \$40.

i. No change.

ITEM 6. Amend subrule 131.5(7) as follows:

**131.5(7) Continuing education renewal.**

a. The table below illustrates the minimum number of core ~~continuing education hours (CEHs)~~ by topic area for each level of emergency medical care provider to renew an Iowa EMS certification.

| Core Topics                        | EMR/FR                       | EMT/EMT-D                      | AEMT                           | PM                             |
|------------------------------------|------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Airway, Respirations, Ventilations | <del>4</del> <u>1.5</u>      | <del>4</del> <u>4</u>          | <del>2</del> <u>5</u>          | <del>3</del> <u>6</u>          |
| Cardiology                         | 2                            | <del>6</del> <u>5</u>          | <del>7</del> <u>6</u>          | <del>9</del> <u>7</u>          |
| Trauma                             | 1                            | <del>2</del> <u>3</u>          | <del>3</del> <u>4</u>          | <del>3</del> <u>5</u>          |
| Medical                            | <del>3</del> <u>2.5</u>      | 6                              | <del>8</del> <u>7</u>          | <del>9</del> <u>8</u>          |
| Operations                         | 1                            | <del>5</del> <u>2</u>          | <del>5</del> <u>3</u>          | <del>6</del> <u>4</u>          |
| Pediatric                          | <u>1</u>                     | <u>2</u>                       | <u>3</u>                       | <u>4</u>                       |
| <b>Totals</b>                      | <b><del>8</del> <u>9</u></b> | <b><del>20</del> <u>22</u></b> | <b><del>25</del> <u>28</u></b> | <b><del>30</del> <u>34</u></b> |

b. All core continuing education hours issued by an Iowa EMS training program, the department, or CAPCE used to renew an Iowa EMS certification must have a sponsor number ~~by an authorized Iowa training program, the department, the board of nursing, the board of medicine, or CAPCE~~ before the emergency medical care provider attends the offering.

c. to e. No change.

f. A group of emergency medical care providers will be audited for each certification period. Emergency medical care providers to be audited will be chosen in a random manner or at the discretion of the department. Falsifying reports or failure to comply with the audit request may result in formal disciplinary action. ~~Those audited must submit a department provided audit report form within 45 days of the request.~~ If audited, within 30 days from the date of request for audit, the emergency medical care provider must provide a copy of the course completion certification or other verifying documentation that contains the following information at a minimum:

- (1) No change.
- (2) Program sponsor number (if applicable).
- (3) and (4) No change.

ITEM 7. Amend subrule 131.5(8) as follows:

**131.5(8)** *Continuing education approval.* The following standards apply for approval of continuing education:

a. CEHs issued by CAPCE, an authorized EMS training program, or the department will have an assigned sponsor number ~~from CAPCE, an authorized EMS training program, the board of nursing, the board of medicine or the department~~ before the emergency medical care provider attends the offering.

b. No change.

c. Courses must be, at a minimum, 30 minutes in duration (one-half CEH). Multi-hour courses are granted credit in half-hour increments (e.g., one hour and 30 minutes = one and one-half CEHs).

d. Continuing education courses that are accepted by the board of nursing and the board of medicine that are directly related to EMS patient care and apply to the core continuing education topics will be accepted.

ITEM 8. Amend paragraph **131.6(4)“e”** as follows:

e. ~~Fraud~~ Misrepresentation in procuring certification or renewal, including but not limited to:

- (1) ~~An intentional~~ A perversion of the truth in making application for a certification to practice in this state;
- (2) and (3) No change.

**RA 26-71****TRANSPORTATION DEPARTMENT[761]****Regulatory Analysis**

Notice of Intended Action to be published: 761—Chapter 301  
“Motor Vehicle Records—Driver’s Privacy Protection and Electronic Communications”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 321A.3, 321.11 and 321.16A  
State or federal law(s) implemented by the rulemaking: Iowa Code sections 321.11 and 321.16A

*Public Hearing*

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

June 23, 2026  
1 to 1:30 p.m.

[Microsoft Teams](#)  
Or dial: 515.817.6093  
Conference ID: 202 653 103#

*Public Comment*

Any interested person may submit written comments concerning this regulatory analysis, which must be received by the Department of Transportation no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Sara Siedsma  
6310 SE Convenience Boulevard  
Ankeny, Iowa 50021  
Email: [Sara.Siedsma@iowadot.us](mailto:Sara.Siedsma@iowadot.us)

*Purpose and Summary*

The purpose of the proposed amendments is to align with 2026 Iowa Acts, Senate File 2088, sections 30 and 31, which classify phone numbers and email addresses as personal information under Iowa Code section 321.11, and to support electronic communication with Motor Vehicle Division customers through the Department’s new information technology (IT) system. Receiving electronic communications through the new system is voluntary and may be in the form of text or email notifications, or documents accessible through the system. The rules provide that the terms of accessing and receiving electronic communications from the Department will be made available to review prior to signing up. The proposed amendments also clarify the definition of “express written consent” and incorporate a 50-cent per record fee for issuing noncertified copies of motor vehicle records as authorized under Iowa Code section 321.11(4). This fee matches the fee charged in Iowa Code section 321.491 for noncertified copies of certain records provided by the clerk of the district court, which are transferred to the Department as appropriated receipts.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

Iowa Code section 321.11(4) authorizes the Department to collect reasonable fees for the provision of records. Under the proposed rule, persons requesting noncertified copies of motor vehicle records may incur a 50-cent per record fee.



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

Persons intending to receive electronic communications from the Department's new system will benefit from having the chapter reflect and expand on the process authorized in statute.

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

- **Quantitative description of impact:**

Persons requesting noncertified copies of motor vehicle records may incur a 50-cent per record fee.

- **Qualitative description of impact:**

There are no qualitative impacts.

**3. Costs to the State:**

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

There are no implementation or enforcement costs beyond those of the underlying statute.

- **Anticipated effect on State revenues:**

The Department estimates collecting approximately \$3,678.75 in fees annually for the noncertified record fee.

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

The benefit of the proposed amendments is consistency and transparency for those receiving electronic communications from the Department and requesting noncertified copies of motor vehicle records. The cost of inaction is the inability for the public to be fully informed regarding the electronic communications process and noncertified record fee.

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

There are no less costly or less intrusive methods to achieve the purpose of the proposed rulemaking, which allows the Department to communicate via electronic methods and collect reasonable fees for provision of motor vehicle records.

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

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

The Department did not consider alternatives for the proposed rules. The 50-cent noncertified record fee matches the fee charged in Iowa Code section 321.491 for noncertified copies of certain records provided by the clerk of the district court, which are transferred to the Department as appropriated receipts.

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

Not applicable.

*Small Business Impact*

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

There is no small business impact from the proposed rulemaking.

*Text of Proposed Rulemaking*

ITEM 1. Amend **761—Chapter 301**, title, as follows:

**DRIVER'S PRIVACY PROTECTION—MOTOR VEHICLE RECORDS—DRIVER'S PRIVACY PROTECTION AND ELECTRONIC COMMUNICATIONS**

ITEM 2. Amend rule 761—301.1(321) as follows:

**761—301.1(321) Applicability and adoption.** This chapter applies to personal information and highly restricted personal information in motor vehicle records of the department and electronic communications from the department's records system. The department adopts the Driver's Privacy Protection Act of 1994 (18 U.S.C. §2721 and 2725 effective as of October 23, 2000, and 18 U.S.C. §2722 through 2724 effective as of September 13, 1994) for motor vehicle records. The department does not provide the waiver procedure described in the Driver's Privacy Protection Act (codified as 18 U.S.C. §2721(d) effective as of October 23, 2000).

This rule is intended to implement Iowa Code section 321.11 and section 321.16A as enacted by 2026 Iowa Acts, Senate File 2088, section 31; 18 U.S.C. §2721 and 2725 effective as of October 23, 2000; and 18 U.S.C. §2722 through 2724 effective as of September 13, 1994.

ITEM 3. Amend rule **761—301.2(321)**, definition of “Express written consent,” as follows:

“*Express written consent*” as used in Iowa Code section 321.11 means the same as “express consent” as used and defined in 18 U.S.C. §2721 and §2725(5) effective as of October 23, 2000, and must either be notarized or accompanied by proof of identity of the ~~requester~~ individual or vehicle owner to whom the information applies.

ITEM 4. Amend rule 761—301.3(321) as follows:

**761—301.3(321) Information and addresses.** Information and forms for records pertaining to motor vehicle records may be obtained at any driver's license service center or electronically from the department's records system; by mail from the Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at any driver's license service center or 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at 515.237.3110; by email at privacy.agreements@iowadot.us; or on the department's website at www.iowadot.gov/mvd/vehicleregistration/records for vehicle records and www.iowadot.gov/mvd/driverslicense/records for driving records.

This rule is intended to implement Iowa Code section 321.11 and section 321.16A as enacted by 2026 Iowa Acts, Senate File 2088, section 31.

ITEM 5. Amend rule 761—301.4(321) as follows:

**761—301.4(321) Requirements and procedures—requesting access to motor vehicle records.**

**301.4(1)** A requester seeking personal information or highly restricted personal information is required to:

*a.* Complete Form 431069, “Privacy Act Agreement for Request of Motor Vehicle Records,” and submit the form to the department's records system, any driver's license service center or the motor vehicle division at the address in rule 761—301.3(321). Requests for information about another individual require completion of Parts A, B (if applicable), C, and D of Form 431069. Requests for an individual's own information require completion of Part A.

*b.* No change.

**301.4(2)** A law enforcement agency that requests personal information or highly restricted personal information is to either follow the process in subrule 301.4(1) or complete and submit Form ~~431200~~ 432069, “Certified Motor Vehicle Record Request Form for Use by County Attorney’s Offices and Law Enforcement Agencies,” to the department’s records system, any driver’s license service center or the motor vehicle division at the address in rule 761—301.3(321). Alternately, a law enforcement agency may enter into a memorandum of understanding with the department for the purposes of requesting personal information or highly restricted personal information.

**301.4(3)** Personal information and highly restricted personal information, except for an individual’s email address, telephone number and photograph or image, may be disclosed with the express written consent of the individual or vehicle owner to whom such information applies. When the requester has obtained the written consent of the individual or vehicle owner to whom the information applies, the requester must attach that written consent on a completed Form 431069, “Privacy Act Agreement for Request of Motor Vehicle Records,” and submit the form to any driver’s license service center or the motor vehicle division at the address in rule 761—301.3(321).

**301.4(4) to 301.4(7)** No change.

This rule is intended to implement Iowa Code sections 321.10, 321.11 as amended by 2026 Iowa Acts, Senate File 2088, section 30, 321.11 and 321.13; 18 U.S.C. §2721 and 2725 effective as of October 23, 2000; and 18 U.S.C. §2722 through 2724 effective as of September 13, 1994.

ITEM 6. Amend rule 761—301.6(321,321A) as follows:

**761—301.6(321,321A) Certified abstract of operating records.**

**301.6(1)** A certified abstract of the operating record includes the information that is on the face of an individual’s driver’s license, plus information on the individual’s sanctions, reportable vehicle accidents, and convictions. The certified abstract of operating record does not include the individual’s email address, telephone number, photograph, social security number, or medical or disability information.

*a.* In accordance with Iowa Code section 321A.3, a certified abstract of operating record can be obtained by following the process outlined in rule 761—301.4(321).

*b.* The statutory fee, if applicable, is due at the time of the request.

**301.6(2) and 301.6(3)** No change.

This rule is intended to implement Iowa Code sections 321.11 as amended by 2026 Iowa Acts, Senate File 2088, section 30, 321.13 and 321A.3; 18 U.S.C. §2721 and 2725 effective as of October 23, 2000; and 18 U.S.C. §2722 through 2724 effective as of September 13, 1994.

ITEM 7. Adopt the following new subrule 301.7(5):

**301.7(5)** A \$0.50 per record fee for noncertified copies of motor vehicle records.

ITEM 8. Adopt the following new rule 761—301.8(321,321A):

**761—301.8(321,321A) Electronic communications.**

**301.8(1)** Pursuant to Iowa Code section 321.16A as enacted by 2026 Iowa Acts, Senate File 2088, section 31, a person may consent to access and receive electronic communications and documents from the department through the department’s records system.

**301.8(2)** Prior to giving consent, the department will make information available through the department’s records system, website or other appropriate method as determined by the department regarding the terms of accessing and receiving electronic communications from the department, including the procedures for withdrawing consent.

**301.8(3)** Personal information and highly restricted personal information will be used and disclosed only as permitted under Iowa Code sections 321.11 and 321.16A and this chapter.

This rule is intended to implement Iowa Code section 321.16A as enacted by 2026 Iowa Acts, Senate File 2088, section 31.

RA 26-72

**TRANSPORTATION DEPARTMENT[761]****Regulatory Analysis**

Notice of Intended Action to be published: 761—subrule 505.2(2)  
“International Motor Fuel Licenses and Permits”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 452A.56

State or federal law(s) implemented by the rulemaking: Iowa Code section 452A.56

*Public Hearing*

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

June 23, 2026  
10:30 to 11 a.m.

[Microsoft Teams](#)  
Or dial: 515.817.6093  
Conference ID: 421 788 948#

*Public Comment*

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

Sara Siedsma  
6310 SE Convenience  
Boulevard  
Ankeny, Iowa 50021  
Email: [sara.siedsma@iowadot.us](mailto:sara.siedsma@iowadot.us)

*Purpose and Summary*

The purpose of the proposed amendment is to adopt the most recent version of the International Fuel Tax Agreement (IFTA) effective January 2026. Iowa Code section 452A.56 authorizes the Department’s membership to and implementation of the agreement for the collection and refund of interstate motor fuel tax. Changes made in the 2026 update include adding new definitions of “kilowatt hour” and “volume,” both of which are intended to further clarify measurement units for fuel taxation and reporting.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs or fees associated with this proposed amendment.

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

Persons seeking to obtain an IFTA fuel license or permit will benefit from having the rule refer to the most recent version of the IFTA agreement.

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

There are no quantitative impacts to updating the reference to the most recent version of the IFTA agreement.

- **Qualitative description of impact:**

There are no qualitative impacts to updating the reference to the most recent version of the IFTA agreement.

3. **Costs to the State:**

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

There are no implementation or enforcement costs because of the proposed amendment.

- **Anticipated effect on State revenues:**

There are no anticipated effects on State revenues because of the proposed amendment.

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

There is no benefit of inaction. Iowa Code section 452A.56 authorizes the Department's membership to and implementation of the IFTA agreement for the collection and refund of interstate motor fuel tax.

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

There are no less costly or less intrusive methods to achieve the purpose of the proposed amendment.

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

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

The Department did not consider alternatives for the proposed rulemaking.

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

Not applicable.

*Small Business Impact*

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

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

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

There is no small business impact from the proposed amendment.

*Text of Proposed Rulemaking*

ITEM 1. Amend subrule 505.2(2) as follows:

**505.2(2)** *Organizational data.* The motor vehicle division is authorized pursuant to Iowa Code chapter 452A to:

- Issue fuel licenses or temporary fuel permits.
- Compute and collect interstate motor fuel taxes.

- c.* Refund overpayments of interstate fuel taxes.
- d.* Administer agreements with other jurisdictions for the collection and refund of interstate motor fuel tax. Pursuant to Iowa Code section 452A.56, the department has adopted and incorporates into this chapter the IFTA effective January ~~2025~~ 2026. IFTA governing documents do not create rights for the taxpayer.

RA 26-73

**TRANSPORTATION DEPARTMENT[761]****Regulatory Analysis**

Notice of Intended Action to be published: rule 761—602.3(321)  
“Driver’s Licenses”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 321.189

State or federal law(s) implemented by the rulemaking: Iowa Code sections 321.180 and 321.189

*Public Hearing*

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

June 23, 2026  
10 to 10:30 a.m.

[Microsoft Teams](#)  
Or dial: 515.817.6093  
Conference ID: 123 320 295#

*Public Comment*

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

Sara Siedsma  
6310 SE Convenience Boulevard  
Ankeny, Iowa 50021  
Email: [sara.siedsma@iowadot.us](mailto:sara.siedsma@iowadot.us)

*Purpose and Summary*

The purpose of the proposed amendment is to conform with 2026 Iowa Acts, Senate File 2088, which eliminates the chauffeur’s instruction permit as a permit type issued by the Department, and updates the rules to reflect how commercial learner’s permits and restricted commercial driver’s licenses will display under the Department’s new information technology (IT) system. The chauffeur’s instruction permit was removed from statute because it is obsolete; individuals can instead use a Class C permit or license to gain the driving experience required for a chauffeur’s license. Additionally, commercial learner’s permits and restricted commercial driver’s licenses will display an identifier for the license type on the front of the credential rather than only a restriction number that is explained on the back of the license.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs or fees associated with this proposed amendment beyond those imposed by the underlying statute.

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

Persons interested in a chauffeur’s license, a commercial learner’s permit or a restricted commercial driver’s license will benefit from having the rule reflect the statute and the new capabilities of the Department’s IT system.

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

- **Quantitative description of impact:**

There are no quantitative impacts.

- **Qualitative description of impact:**

There are no qualitative impacts.

**3. Costs to the State:**

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

There are no implementation or enforcement costs beyond those of the underlying statute.

- **Anticipated effect on State revenues:**

There are no anticipated effects on State revenues beyond those of the underlying statute.

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

There is no benefit of inaction. The proposed amendment conforms with underlying statute and the new capabilities of the Department's IT system.

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

There are no less costly or less intrusive methods to achieve the purpose of the proposed amendment.

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

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

The Department did not consider alternatives for the proposed amendment.

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

Not applicable.

*Small Business Impact*

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

There is no small business impact from the proposed amendment.

*Text of Proposed Rulemaking*

ITEM 1. Amend rule 761—602.3(321) as follows:

**761—602.3(321) Driver's licenses.**

**602.3(1)** No change.

**602.3(2)** *Special licenses and permits.* The department issues the following special licenses and permits. More than one type of special license or permit may be issued to an applicant. On the driver's



license, an identifier or a restriction number designates the type of special license or permit issued as follows:

1—Motorcycle instruction permit—includes motorcycle instruction permits issued under Iowa Code sections 321.180(1) and 321.180B(1)

2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)—includes instruction permits, other than motorcycle instruction permits, issued under Iowa Code sections 321.180(1), 321.180A and 321.180B(1)

~~3—Commercial learner's permit~~

~~4—Chauffeur's instruction permit~~

5—Motorized bicycle (moped) license

6—Minor's restricted work license

7—Special minor's restricted license

8—Special instruction permit

Commercial learner's permit

Restricted commercial driver's license

**602.3(3)** No change.

This rule is intended to implement Iowa Code sections 321.178, 321.180 ~~through~~ as amended by 2026 Iowa Acts, Senate File 2088, section 2, 321.180A, 321.180B, 321.189, and 321.194.

RA 26-74

**TRANSPORTATION DEPARTMENT[761]****Regulatory Analysis**

Notice of Intended Action to be published: 761—Chapter 605  
“License Issuance”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 307.12(1)“j,” 321.182, 321.189, 321.195 and 321.196

State or federal law(s) implemented by the rulemaking: Iowa Code sections 321.182, 321.189, 321.195 and 321.196

*Public Hearing*

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

June 23, 2026  
9:30 to 10 a.m.

[Microsoft Teams](#)  
Or dial: 515.817.6093  
Conference ID: 725 679 574#

*Public Comment*

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

Sara Siedsma  
6310 SE Convenience Boulevard  
Ankeny, Iowa 50021  
Email: [sara.siedsma@iowa.dot.us](mailto:sara.siedsma@iowa.dot.us)

*Purpose and Summary*

The purpose of the proposed amendments is to align the rules with 2026 Iowa Acts, Senate File 2088, section 16, which authorizes the Department to provide electronic driver’s license replacement services through the Department’s new information technology (IT) system. These amendments also update the rules to reflect how the new system will process other driver’s license issuance transactions, including electronic renewals, and make corresponding technical and citation changes throughout the chapter.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs or fees associated with the proposed amendments. The amendments reflect how the Department will deliver services through its new IT system.

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

Persons seeking to obtain a driver’s license will benefit from knowing how services will be provided through the Department’s new IT system.

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

- **Quantitative description of impact:**

There are no quantitative impacts beyond those of the underlying statute.

- **Qualitative description of impact:**

There are no qualitative impacts beyond those of the underlying statute.

3. **Costs to the State:**

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

There are no implementation or enforcement costs beyond those of the underlying statute.

- **Anticipated effect on State revenues:**

There are no anticipated effects on State revenues beyond those of the underlying statute.

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

There is no benefit of inaction. This rulemaking conforms with underlying statute and the capabilities of the Department's new IT system.

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

There are no less costly or less intrusive methods to achieve the purpose of the proposed amendments.

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

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

The Department did not consider alternatives for the proposed rules.

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

Not applicable.

*Small Business Impact*

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

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

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

There is no small business impact from the proposed rulemaking.

*Text of Proposed Rulemaking*

ITEM 1. Amend rule 761—605.2(307,321), definitions of “Qualified medical professional” and “Temporarily present in this state,” as follows:

“*Qualified medical professional*” means a person licensed as a physician under Iowa Code chapter 148, a person licensed as an advanced registered nurse practitioner under Iowa Code chapter 152 and licensed with the board of nursing or a person licensed as a physician ~~assistant~~ associate under Iowa Code chapter 148C as amended by 2026 Iowa Acts, Senate File 2190, section 3, when practicing within the scope of the person's professional licensure.

“*Temporarily present in this state*” means a person who has temporary lawful status as defined in 6 CFR Section 37.3 effective January 1, ~~2024~~ 2025.

ITEM 2. Amend subrule 605.3(3) as follows:

**605.3(3)** When the department receives evidence that an Iowa licensed driver has been adjudged incompetent or is not physically or mentally qualified to operate a motor vehicle safely, the department will deny or suspend the license for incapability, as explained in rule 761—615.14(321); or deny further licensing, as explained in rule 761—615.4(321) 761—615.7(321).

ITEM 3. Amend rule 761—605.4(142C,321) as follows:

**761—605.4(142C,321) Contents of license.** In addition to the information specified in Iowa Code section 321.189(2), the following information will be shown on a driver’s license.

**605.4(1) Name.** The licensee’s full legal name will be listed as established according to ~~761—subrules 601.5(1) and 601.5(5)~~ 761—subrules 601.4(1) and 601.4(5) and will conform to the requirements of ~~761—subrule 601.1(2)~~ 761—subrule 601.2(1).

**605.4(2) Current residential address.** The licensee’s current residential address will be listed as established according to the requirements of ~~761—subrule 601.1(6) and 761—subrule 601.5(3)~~ 761—subrules 601.2(5) and 601.4(3).

**605.4(3) Physical description.** The physical description of the licensee on the face of the driver’s license will include the following as established according to the requirements of ~~761—subrule 601.1(5)~~ 761—subrule 601.2(4):

a. and b. No change.

**605.4(4) Date of birth.** The licensee’s date of birth will be listed as established according to ~~761—subrules 601.5(1) and 601.5(6)~~ 761—subrules 601.4(1) and 601.4(6).

**605.4(5) Sex.** The licensee’s sex will be identical to the sex listed on the identity document submitted under ~~rule 761—601.5(321)~~ 761—subrule 601.4(1).

**605.4(6) REAL ID markings.**

a. A driver’s license that is issued as a REAL ID driver’s license as defined in rule ~~761—601.7(321)~~ 761—601.6(321) will include a security marking as required by 6 CFR Section 37.17(n) effective January 1, ~~2024~~ 2025.

b. A driver’s license that is not issued as a REAL ID driver’s license as defined in rule ~~761—601.7(321)~~ 761—601.6(321) is to include the following statement on the face of the card: “not for REAL ID act purposes” as required by 6 CFR Section 37.71 effective January 1, ~~2024~~ 2025, and any subsequent guidance issued by the U.S. Department of Homeland Security.

c. No change.

**605.4(7)** No change.

This rule is intended to implement ~~Iowa Code section 4.1A as enacted by 2025 Iowa Acts, Senate File 418; Iowa Code sections 4.1A,~~ 142C.3 and 321.189; the REAL ID Act of 2005 (49 U.S.C. Section 30301 note) as amended by the REAL ID Modernization Act, H.R. 133, Division U, Title X; and 6 CFR Part 37.

ITEM 4. Amend rule 761—605.5(321) as follows:

**761—605.5(321) License class.** The driver’s license class will be ~~eoded~~ identified on the face of the driver’s license ~~using these codes as follows:~~

Class A—commercial driver’s license

Class B—commercial driver’s license

Class C—commercial driver’s license

Class C—noncommercial driver’s license

Class D—noncommercial driver’s license, chauffeur

Class M—noncommercial driver’s license, motorcycle only

Commercial learner’s permit

Restricted commercial driver's license

This rule is intended to implement Iowa Code section 321.189.

ITEM 5. Amend rule 761—605.7(321) as follows:

**761—605.7(321) Restrictions.** Restrictions will be coded on the face of the driver's license and explained in text on the front or back of the driver's license or in the department's records system, depending on the nature of the restriction. For purposes of this rule, "CMV" means commercial motor vehicle.

**605.7(1)** *For all licenses.* The following restrictions may apply to any driver's license:

B—Corrective lenses required

C—Mechanical aid (as detailed in the restriction on the back of the card)

D—Prosthetic aid (as detailed in the restriction on the back of the card)

F—Left and right outside rearview mirrors

G—No driving when headlights required

H—Temporary restricted license or permit (work permit)

I—Ignition interlock required

J—Restrictions on the back of card

S—SR required (proof of financial responsibility for the future)

~~T—Medical report required at renewal~~

U—Not valid for two-wheel vehicle

W—Restricted commercial driver's license (CDL)

Y—Intermediate license

**605.7(2) to 605.7(4)** No change.

**605.7(5)** *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

1—Motorcycle instruction permit

2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)

~~3—Commercial learner's permit~~

5—Motorized bicycle license

6—Minor's restricted work license

7—Special minor's restricted license

**605.7(6)** No change.

This rule is intended to implement Iowa Code chapter 321A and sections 321.177, 321.178, 321.180 through 321.180B, 321.186, 321.188, 321.189, 321.193, 321.194, 321.215, 321J.4 and 321J.20.

ITEM 6. Amend rule 761—605.8(321) as follows:

**761—605.8(321) Credential term for a foreign national temporarily present in this state.** A driver's license or nonoperator's identification card issued to a person who is a foreign national who is temporarily present in this state shall be issued only for the length of time the person is authorized to be present in the United States as verified by the department, not to exceed two years, pursuant to 6 CFR Section 37.21 effective January 1, ~~2024~~ 2025. However, if the person's lawful status has no expiration date, the driver's license will be issued for a period of no longer than one year.

This rule is intended to implement Iowa Code section 321.196; the REAL ID Act of 2005 (49 U.S.C. Section 30301 note) as amended by the REAL ID Modernization Act, H.R. 133, Division U, Title X; and 6 CFR Part 37.

ITEM 7. Amend subrules 605.9(1) to 605.9(2) as follows:

**605.9(1)** If the payment is by check, the check ~~shall be for the exact~~ cannot exceed the total amount of the fee and that is due but the check can be for an amount less than the total amount if

combined with another payment method. All checks must be payable to: Treasurer, State of Iowa. An exception may be made when a traveler's check is presented.

**605.9(2)** One payment method, or split payment methods, may be used to pay fees for several persons, such as members of a family or employees of a business firm. One payment method, or split payment methods, may pay all fees involved, such as the license fee and the reinstatement fee.

ITEM 8. Amend rule 761—605.10(307,321) as follows:

**761—605.10(307,321) Duplicate license.**

**605.10(1)** *Lost, stolen or destroyed license.* Prior to replacing a valid license that is lost, stolen or destroyed, the department will verify the licensee's full legal name, date of birth and social security number and collect the replacement fee. A licensee subject to ~~761—paragraph 601.5(2)~~ 761—paragraph 601.4(2) "b" shall provide the applicant's U.S. Customs and Immigration Services number, which must be verified by the department. The department may investigate or require additional information as may be reasonably necessary to determine that the licensee's identity matches the identity of record and will not issue the replacement license if the licensee's identity is questionable, cannot be determined or otherwise does not match the identity of record.

**605.10(2)** *Voluntary replacement.* The department will issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the replacement fee is paid. Voluntary replacement includes but is not limited to:

*a.* to *g.* No change.

*h.* Replacement of a valid license before its expiration date to obtain a license that may be accepted for federal identification purposes under 6 CFR Part 37 effective January 1, 2024 2025 (a REAL ID driver's license).

*i.* No change.

**605.10(3)** ~~*Replacement upon attaining the age of 21*~~ *Electronic replacement.* ~~A licensee, upon attaining the age of 21, who is otherwise eligible for a driver's license is eligible to electronically apply for a replacement driver's license under this rule for the unexpired months of the license, regardless of whether the most recent issuance occurred electronically. An applicant who meets the eligibility criteria may apply for electronic replacement of driver's license.~~

~~*a.* Except for the requirements in subparagraphs 605.15(6) "a" (1) and "a" (2), the licensee must meet the eligibility requirements listed in paragraph 605.15(6) "a" or 605.15(7) "a" to replace the license electronically in addition to the following criteria:~~

~~(1) The licensee must be at least 21 years old.~~

~~(2) The licensee must currently hold a driver's license marked "under 21" as provided in Iowa Code section 321.189.~~

~~*b.* Notwithstanding any other provision of this chapter to the contrary, the department may accept an electronic replacement application if the licensee seeks replacement of a special instruction permit or a license with a single "J" restriction accompanied by a "9" restriction.~~

~~*a.* Eligibility criteria include the following:~~

~~(1) The applicant is at least 14 years of age but not yet 70 years of age.~~

~~(2) The applicant's driver's license has not been expired for more than one year.~~

~~(3) The applicant's driver's license is eligible for reinstatement from a suspension that does not require an "H" or "I" restriction and all reinstatement criteria have been satisfied.~~

~~(4) The department's records show the applicant is a U.S. citizen and Iowa resident.~~

~~(5) The applicant's driver's license is not marked "valid without photo."~~

~~(6) The applicant is not subject to a pending request for reexamination.~~

~~(7) The applicant is not required to submit a medical report or vision report as a condition of licensure.~~

~~(8) The applicant is not seeking to change any of the following information as it appears on the applicant's driver's license:~~

~~1. Name.~~

2. Date of birth.

3. Class of license.

(9) The applicant is not subject to any of the following restrictions or endorsements:

E—No manual transmission equipped CMV

G—No driving when headlights required

H—Hazardous material

Q—No interstate or freeway driving

X—Hazardous material and tank

b. Notwithstanding any other provision of this subrule to the contrary, the department may accept an electronic replacement application if the license contains any of the following:

(1) A “J” restriction unless the restriction requires supervision of the driver by occupational therapy staff or is a specialized, nonstandard restriction.

(2) A “K” restriction that the applicant is electing to add or remove.

(3) An “H,” “I,” “S,” “W” or “9” restriction if the restriction is no longer applicable or required.

(4) Expired privileges, endorsements or certifications, which will be removed at issuance.

c. The department may deny electronic replacement and require the applicant to appear in person for a replacement at a driver’s license service center, including if it appears to the department that the applicant may have a physical or mental condition that may impair the applicant’s ability to safely operate a motor vehicle, even if the applicant otherwise meets the criteria in paragraph 605.10(3) “a.”

d. An applicant who has not previously been issued a driver’s license that is compliant with the REAL ID Act of 2005, 49 U.S.C. Section 30301 note, implemented in 6 CFR Part 37 effective January 1, 2025 (a REAL ID driver’s license), cannot request a REAL ID driver’s license by electronic replacement.

This rule is intended to implement Iowa Code sections 307.12(1) “j,” 321.13, 321.189, 321.195 as amended by 2026 Iowa Acts, Senate File 2088, section 26, and 321.208; the REAL ID Act of 2005 (49 U.S.C. Section 30301 note) as amended by the REAL ID Modernization Act, H.R. 133, Division U, Title X; and 6 CFR Part 37.

ITEM 9. Amend subrule 605.14(2) as follows:

**605.14(2)** The fee to add a privilege to a driver’s license is computed per year of new license validity as follows:

|                                             |              |
|---------------------------------------------|--------------|
| Noncommercial Class C                       | \$4 per year |
| (full privileges from a restricted Class C) |              |
| Motorized bicycle                           | \$4 per year |
| Minor’s restricted license                  | \$4 per year |
| Special minor’s restricted license          | \$4 per year |
| Motorcycle instruction permit               | \$2 per year |
| Motorcycle endorsement                      | \$2 per year |

ITEM 10. Amend rule 761—605.15(307,321) as follows:

**761—605.15(307,321) License renewal.**

**605.15(1)** No change.

**605.15(2)** A valid noncommercial license may be renewed within 180 days before the expiration date. The department for good cause may renew a noncommercial license earlier, except the department will not renew a REAL ID driver’s license issued under rule 761—601.7(321) 761—601.6(321) earlier than 180 days before the expiration date if such a renewal would result in noncompliance under 6 CFR Section 37.5(a) effective January 1, 2024 2025.

**605.15(3)** If the licensee’s current residential address, name or date of birth has changed since the previous license was issued, the licensee shall:

a. Notify the department to establish the current residential address.

b. Comply with the requirements of ~~761—subrule 601.5(5)~~ 761—subrule 601.4(5) to establish a name change.

c. Comply with the requirements of ~~761—subrule 601.5(6)~~ 761—subrule 601.4(6) to establish a change of date of birth.

**605.15(4)** A licensee who has not previously been issued a license that may be accepted for federal identification purposes under 6 CFR Part 37 effective January 1, 2024 2025 (a REAL ID driver's license), and wishes to obtain a REAL ID driver's license upon renewal must comply with the requirements of rule ~~761—601.5(321)~~ 761—601.4(321) to obtain a REAL ID driver's license upon renewal.

**605.15(5)** A licensee who is a foreign national who is temporarily present in this state must provide documentation of lawful status as required by ~~761—subrule 601.5(4)~~ 761—subrule 601.4(4) at each renewal.

**605.15(6)** An applicant who meets the eligibility criteria may apply for electronic renewal of a noncommercial driver's license.

a. Eligibility criteria include the following:

(1) to (9) No change.

(10) The applicant is not subject to any of the following restrictions:

G—No driving when headlights required

J—Restrictions on the back of card

T—~~Medical report required at renewal~~

8—Special instruction permit

Q—No interstate or freeway driving

b. Notwithstanding any other provision of this subrule to the contrary, the department may accept an electronic renewal application if the license contains ~~a single “J” restriction accompanied by a “7” or “Y” restriction.~~ any of the following:

(1) A “J” restriction accompanied by a “7” or “Y” restriction or a “J” restriction accompanying an “H” or “X” endorsement that is being removed.

(2) An “H,” “I,” “S,” “W” or “9” restriction if the restriction is no longer applicable or required.

(3) A motorcycle endorsement that the licensee is electing to remove.

(4) Expired privileges, endorsements or certifications, which will be removed at issuance.

c. The department may deny electronic renewal and require the applicant to apply in person for renewal at a driver's license service center, including if it appears to the department that the applicant may have a physical or mental condition that may impair the applicant's ability to safely operate a motor vehicle, even if the applicant otherwise meets the criteria in paragraph 605.15(6) “a.”

d. An applicant who has not previously been issued a driver's license that is compliant with the REAL ID Act of 2005, 49 U.S.C. Section 30301 note, implemented in 6 CFR Part 37 effective January 1, 2024 2025 (a REAL ID driver's license), cannot request a REAL ID driver's license by electronic renewal.

**605.15(7)** Subject to the requirements in paragraphs 605.15(6) “c” and “d,” an applicant who meets the following eligibility criteria may apply for electronic renewal of a commercial driver's license:

a. The applicant is otherwise eligible to renew a commercial driver's license and meets the same eligibility requirements for renewing a noncommercial driver's license listed in paragraph 605.15(6) “a” to renew the license electronically, except that numbered paragraph 605.15(6) “a”(9)“3” does not apply if the applicant is adding or removing the “K” restriction from the license at the time of renewal: and numbered paragraph 605.15(6) “a” (9)“2” does not apply if the applicant is removing either endorsement under paragraph 605.15(7) “b.”

b. The applicant is not subject to any either of the following ~~restrictions or endorsements unless electing to remove either endorsement:~~

H—Hazardous material

X—Hazardous material and tank



*c.* The applicant does not also hold a valid commercial learner's permit under Iowa Code section 321.180(2) ~~as documented by restriction "3" on the commercial driver's license.~~

*d.* No change.

This rule is intended to implement Iowa Code sections 307.12(1) "j," 321.186, 321.188 and 321.196; the REAL ID Act of 2005 (49 U.S.C. Section 30301 note) as amended by the REAL ID Modernization Act, H.R. 133, Division U, Title X; and 6 CFR Part 37.

RA 26-75

**TRANSPORTATION DEPARTMENT[761]****Regulatory Analysis**

Notice of Intended Action to be published: 761—Chapter 620  
“OWI and Implied Consent”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 307.12(1)“j,” 321J.17 and 321J.17A  
State or federal law(s) implemented by the rulemaking: Iowa Code sections 321J.17, 321J.17A  
and 321J.20

*Public Hearing*

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

June 23, 2026  
1:30 to 2 p.m.

[Microsoft Teams](#)  
Or dial: 515.817.6093  
Conference ID: 223 340 30#

*Public Comment*

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

Sara Siedsma  
6310 SE Convenience Boulevard  
Ankeny, Iowa 50021  
Email: [sara.siedsma@iowadot.us](mailto:sara.siedsma@iowadot.us)

*Purpose and Summary*

The purpose of the proposed amendments is to clarify that reports of installations and deinstallations of ignition interlock devices from providers are to be submitted to the Department electronically through the Department’s new information technology (IT) system and provide greater flexibility in the issuance, as authorized by Iowa Code section 321J.20(6), of temporary restricted license extensions after an operating while intoxicated (OWI) license revocation period has ended.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:**

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

There are no costs or fees associated with these proposed amendments. Electronic submission of notices of installation and deinstallation of ignition interlock devices is a functionality being built into the Department’s new IT system.

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

Persons having to install an ignition interlock device as a condition of a temporary restricted license or license reinstatement will benefit from having notices of installation and deinstallation of the devices submitted electronically, which allows for quicker processing. Persons seeking an extension of a temporary restricted license after the person’s OWI license revocation has ended will benefit from the greater flexibility in the rule allowing the Department to automatically extend the

temporary restricted license for six months, while still retaining the ability to extend for a longer period for reasons of hardship.

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

- **Quantitative description of impact:**

There are no quantitative impacts.

- **Qualitative description of impact:**

There are no qualitative impacts.

**3. Costs to the State:**

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

There are no implementation or enforcement costs because of the proposed amendments.

- **Anticipated effect on State revenues:**

There are no anticipated effects on State revenues because of the proposed amendments.

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

There is no benefit of inaction. Submission of notices of installation and deinstallation of ignition interlock devices electronically through the Department's new IT system will allow for quicker processing, and persons seeking an extension of a temporary restricted license after the person's OWI license revocation has ended will benefit from the greater flexibility in the chapter allowing the Department to automatically extend the temporary restricted license for six months, while still retaining the ability to extend for a longer period for reasons of hardship.

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

There are no less costly or less intrusive methods to achieve the purpose of the proposed amendments.

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

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

The Department did not consider alternatives for the proposed amendments.

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

Not applicable.

*Small Business Impact*

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

There is no small business impact from the proposed amendments.

*Text of Proposed Rulemaking*

ITEM 1. Amend paragraph **620.3(2)“b”** as follows:

*b.* Provide certification of installation of an approved ignition interlock device on each vehicle required pursuant to Iowa Code section 321J.20(2) unless proof of installation is provided to the department electronically by the ignition interlock device provider.

ITEM 2. Amend subrule 620.4(2) as follows:

**620.4(2)** *Electronic reporting.*

*a.* An approved ignition interlock device provider shall electronically report ~~a notice of violation occurrence and a final compliance report to the department in a manner approved by the department.~~, in a manner approved by the department, the following notices and reports:

(1) Notices of installation and deinstallation of ignition interlock devices.

(2) Notices of violation occurrences.

(3) Final compliance reports.

*b.* An approved ignition interlock provider shall retain all data, information and records associated with a notice of violation occurrence and final compliance report for a period of at least five years and make such data available to the department upon request.

ITEM 3. Amend rule 761—620.7(307,321,321J) as follows:

**761—620.7(307,321,321J) Issuance of temporary restricted license after revocation period has expired.** The department may automatically issue a temporary restricted license under Iowa Code section 321J.20(6) for six months from the end of the original revocation, ~~unless if~~ a longer period of time is necessary to complete the requirements for driver's license reinstatement.

**620.7(1)** ~~An~~ For extensions beyond six months, an applicant for a temporary restricted license under this rule must demonstrate to the satisfaction of the department one of the following:

*a.* That a course for drinking drivers was not readily available to the person during the revocation period and the six-month period after the revocation and that the applicant has enrolled in a course for drinking drivers. The applicant must furnish the dates the class will begin and end.

*b.* and *c.* No change.

**620.7(2)** No change.

RA 26-76

**TRANSPORTATION DEPARTMENT[761]****Regulatory Analysis**

Notice of Intended Action to be published: rule 761—640.3(321,321A)  
“Financial Responsibility”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 321A.2

State or federal law(s) implemented by the rulemaking: Iowa Code sections 321.266, 321.271, 321A.4 and 321A.5

*Public Hearing*

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

June 23, 2026  
9 to 9:30 a.m.

[Microsoft Teams](#)  
Or dial: 515.817.6093  
Conference ID: 918 455 051#

*Public Comment*

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

Sara Siedsma  
6310 SE Convenience Boulevard  
Ankeny, Iowa 50021  
Email: [sara.siedsma@iowadot.us](mailto:sara.siedsma@iowadot.us)

*Purpose and Summary*

The purpose of the proposed amendment is to conform with 2026 Iowa Acts, Senate File 2088, which requires accident reports to be submitted to the Department electronically. Electronic submission of accident reports is already possible through the Department’s existing information technology (IT) system, and the functionality will also be built into the Department’s new IT system.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs or fees associated with this proposed amendment. Electronic submission of accident reports is already possible through the Department’s existing IT system, and the functionality will also be built into the Department’s new IT system.

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

Persons submitting accident reports to the Department will benefit from having the rule conform with the statute requiring electronic submission.

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

There are no quantitative impacts.

- **Qualitative description of impact:**

There are no qualitative impacts.

3. **Costs to the State:**

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

There are no implementation or enforcement costs because of the proposed amendment.

- **Anticipated effect on State revenues:**

There are no anticipated effects on State revenues because of the proposed amendment.

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

There is no benefit of inaction. Submission of accident reports electronically allows for quicker processing and more efficient handling and storage of documents.

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

There are no less costly or less intrusive methods to achieve the purpose of the proposed amendment.

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

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

The Department did not consider alternatives for the proposed amendment.

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

Not applicable.

*Small Business Impact*

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

There is no small business impact from the proposed amendment.

*Text of Proposed Rulemaking*

ITEM 1. Amend rule 761—640.3(321,321A) as follows:

**761—640.3(321,321A) Accident reporting requirements.** Accident reporting requirements are specified in Iowa Code section 321.266 and on Form 433002, "Iowa Accident Report Form," which is available from law enforcement officers, driver's license service centers, or the motor vehicle division at the address in subrule 640.1(3). Accident reports are to be submitted to the department in an electronic format accessible through or connected with the department's records system.

This rule is intended to implement Iowa Code sections 321.266, 321.269 and, 321.271 as amended by 2026 Iowa Acts, Senate File 2088, section 10, 321A.4, and 321A.5 as amended by 2026 Iowa Acts, Senate File 2088, section 11.

**RA 26-77****BANKING DIVISION[187]****Regulatory Analysis**

Notice of Intended Action to be published: 187—Chapter 10  
“Electronic Transfer of Funds”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 524.213 and 527.11  
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 527

*Public Hearing*

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

|                         |                                                        |
|-------------------------|--------------------------------------------------------|
| June 16, 2026<br>9 a.m. | Suite 300<br>200 East Grand Avenue<br>Des Moines, Iowa |
| June 18, 2026<br>9 a.m. | Suite 300<br>200 East Grand Avenue<br>Des Moines, Iowa |

*Public Comment*

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

Zak Hingst  
200 East Grand Avenue, Suite 300  
Des Moines, Iowa 50309-1827  
Phone: 515.242.0332  
Email: [zak.hingst@idob.state.ia.us](mailto:zak.hingst@idob.state.ia.us)

*Purpose and Summary*

Pursuant to Executive Order 10 (2023), the Division proposes to rescind Chapter 10 and adopt a new chapter in lieu thereof. This proposed rulemaking eliminates language that is duplicative of statutory language, eliminates unnecessary and inconsistent language, removes unnecessarily restrictive terms, and updates outdated language.

*Analysis of Impact***1. Persons affected by the proposed rulemaking:****• Classes of persons that will bear the costs of the proposed rulemaking:**

People interested in operating or applying to operate a central routing unit in Iowa and financial institutions that establish satellite terminals and issue debit cards to Iowa customers will bear the costs of the proposed rulemaking.

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

People interested in operating or applying to operate a central routing unit in Iowa and financial institutions establishing satellite terminals and issuing debit cards to Iowa customers will benefit from the increased clarity of the chapter and expectations regarding the requirements to operate a

central routing unit. Iowans who utilize debit cards issued by financial institutions in Iowa will also benefit from the continued ability to utilize debit cards that comply with all the routing and security requirements of Iowa Code chapter 527.

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

- **Quantitative description of impact:**

People who apply for approval to operate a central routing unit or to establish a satellite terminal may incur costs to draft an application or other associated documents. The amount of those costs will vary depending on the complexity of the application and the compensation paid to staff or other service providers who draft the documents.

- **Qualitative description of impact:**

This proposed rulemaking will provide clarity about the Division's process for receiving and processing applications to operate a central routing unit and to establish satellite terminals, as well as providing clarity about the compliance and examination standards for approved central routing units.

**3. Costs to the State:**

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

The Division incurs staff time to process and review applications to operate a central routing unit or to establish a satellite terminal.

- **Anticipated effect on State revenues:**

The proposed rulemaking has no anticipated effect on State revenues.

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

The proposed rulemaking does not impose any additional costs on people filing applications to operate an approved central routing unit or to establish a satellite terminal compared to the existing Chapter 10, and it benefits applicants by providing clarity about the process and requirements associated with engaging in these activities for which the Division's approval is statutorily required. The cost of inaction would be lack of guidance for people interested in obtaining approval to operate an approved central routing unit or to establish a satellite terminal, which would engender confusion about the applicable process and requirements for obtaining that approval and for operating in compliance with the Iowa Code.

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

The Division has not identified any less costly or less intrusive methods of approving applicants to operate a central routing unit or establish a satellite terminal or to establish compliance requirements and examination procedures for an approved central routing unit.

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

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

The Division did not consider any alternative methods.

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

The Division did not consider any alternative methods because the Division did not identify any less costly or less intrusive methods of approving applicants to operate a central routing unit or establish a satellite terminal or to establish compliance requirements and examination procedures for an approved central routing unit.

*Small Business Impact*

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



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

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

The proposed rules do not have a substantial impact on small business.

*Text of Proposed Rulemaking*

ITEM 1. Rescind 187—Chapter 10 and adopt the following new chapter in lieu thereof:

CHAPTER 10  
ELECTRONIC TRANSFER OF FUNDS

**187—10.1(527) Scope.** Iowa Code section 527.3 authorizes the administrator to issue rules applicable to financial institutions regarding the operation or control of a satellite terminal or pertaining to a financial transaction engaged in through a satellite terminal. When the term “administrators” appears in this chapter, it signifies that joint action or enforcement may be taken by the administrators specified in Iowa Code sections 527.2 and 527.3.

This rule is intended to implement Iowa Code sections 527.2 and 527.3.

**187—10.2(527) Terms defined.** For the purpose of these rules, the following terms have the meaning indicated in this chapter. The definitions set out in Iowa Code section 527.2 are incorporated in these rules.

“*Cardholder*” means a person who has received an access device from a cardholder financial institution to access the customer asset account(s) maintained at that financial institution by means of a satellite terminal.

“*Cardholder financial institution*” means the financial institution maintaining the customer asset account(s) of a cardholder that is accessible by means of an access device issued by that financial institution.

“*Certification*” means the process by which a central routing unit ensures that access devices, satellite terminals, software vendors, and the data processing center of an establishing or cardholder financial institution meet certain minimum operational standards established by the central routing unit to ensure that the central routing unit and electronic funds transfer system are in compliance with Iowa Code chapter 527. The certification process may be performed by a central routing unit prior to initial operation of a satellite terminal or data processing center and at any subsequent time as determined appropriate by a central routing unit to ensure continued compliance with Iowa Code chapter 527.

“*Customer card number*” means a unique number assigned to each cardholder to identify the cardholder financial institution, the cardholder, and the particular business location or office of the cardholder financial institution where the cardholder’s customer asset account(s) is maintained that may be accessed by the access device.

“*Electronic funds transfer system*” means the electronic system used to process transactions initiated at a satellite terminal and includes the access device, the satellite terminal, the cardholder financial institution and its data processing center, the establishing financial institution and its data processing center, and a central routing unit.

*“Establishing financial institution”* means the financial institution that owns or retains control of a satellite terminal.

*“Front-end processor”* means a data processing facility directly connected to an on-line point-of-sale terminal, as defined by Iowa law, which is utilized in an electronic funds transfer system in conjunction with another data processing facility that is certified by an approved central routing unit. A front-end processor and certified data processing facility that are directly connected constitute a single data processing center, as defined by Iowa law, only if the following specified conditions are satisfied:

1. All on-line point-of-sale satellite terminal transactions received by the front-end processor of the certified data processing facility that cannot be immediately authorized or rejected by the certified data processing facility must be immediately transmitted to an approved central routing unit, subject to the exceptions in Iowa Code section 527.5(9); and

2. All on-line point-of-sale satellite terminal transactions received by the front-end processor of the certified data processing facility that are capable of being immediately authorized or rejected by the certified data processing facility must be transactions initiated by cardholders of financial institutions directly serviced by the certified data processing facility and be immediately authorized or rejected by the certified data processing facility.

*“Reversal”* means the procedure implemented to cancel a previously transmitted transaction from a satellite terminal initiated by a cardholder through the use of an access device. A reversal may be cardholder-generated or system-generated.

*“Switch-behind”* means an electronic funds transfer system configuration in which a satellite terminal is directly connected to the establishing financial institution’s data processing center, which is directly connected to a central routing unit.

*“Switch-in-front”* means an electronic funds transfer system configuration in which a satellite terminal is directly connected to a central routing unit.

*“Transaction”* means each separate, identifiable financial function as authorized by Iowa Code chapter 527, performed at a satellite terminal capable of completing the financial function by a cardholder properly using an access device and an electronic personal identifier at the satellite terminal.

This rule is intended to implement Iowa Code section 527.2.

#### **187—10.3(527) Applications to operate a central routing unit.**

**10.3(1)** *Approval required.* A central routing unit shall not be operated in the state of Iowa unless written approval for that operation has been obtained from the administrators.

**10.3(2)** *Application requirements.* A person desiring to operate a central routing unit shall submit to the administrators an application that shall contain all of the information and be accompanied by all documentation expressly provided for in Iowa Code section 527.9. The administrators will notify the applicant in writing whether the application is considered complete.

**10.3(3)** *Incomplete applications.* If the application is found by the administrators to be incomplete, the applicant will be notified within a reasonable period of that fact and of the specific deficiencies. The application may be denied for lack of information 30 days following any such notification if requested supplemental information is not timely submitted by the applicant.

**10.3(4)** *Final notice.* The administrators shall act on a complete application for operation of a central routing unit within 60 days after the date of written notice to the applicant that the application is determined to be complete. The administrators shall notify the applicant in writing as to the decision to approve or disapprove.

This rule is intended to implement Iowa Code section 527.9.

#### **187—10.4(527) Compliance examinations of a central routing unit.**

**10.4(1)** *Performance examinations.* The administrators may conduct an examination of a central routing unit pursuant to Iowa Code section 527.9(4) at any time after the central routing unit is

operating under the approval of the administrators and shall conduct an examination at the time the approval of the administrators is sought in accordance with rule 187—10.3(527).

**10.4(2) Compliance factors.** A compliance examination of a central routing unit conducted by the administrators shall consider the following factors to ensure that the central routing unit and all other components of an electronic funds transfer system are in full compliance with the requirements of Iowa Code chapter 527.

*a. Transaction charges.* The transaction charges paid to the central routing unit by each financial institution that utilizes the central routing unit must be consistent with the schedule of charges set forth in the application to operate a central routing unit and with the requirements of Iowa Code section 527.5(6).

*b. Transmission capabilities.* The central routing unit must be capable of accepting and routing and, if approved to operate, be operated to accept and route transmissions of transaction data originating at any satellite terminal located in the state, whether receiving transaction data from a satellite terminal or from a data processing center or other central routing unit.

*c. Connections with data processing centers.* The central routing unit must be directly connected to every data processing center that is directly connected to a satellite terminal located in the state.

*d. Transaction requirements.* A central routing unit must ensure that an electronic funds transfer system consistently complies with the following transaction requirements:

(1) All cardholders initiating transactions at satellite terminals must use an access device and an electronic personal identifier issued by the cardholder financial institution unless the use of an electronic personal identifier is not required by Iowa Code chapter 527 for transactions initiated at specified types of satellite terminals.

(2) All transactions must originate at satellite terminals certified by a central routing unit. Satellite terminals located in this state must meet all applicable state and federal requirements.

(3) All transactions shall be authorized either on an on-line real-time basis or on a batch basis through a data processing center or a central routing unit.

(4) All transactions must route in accordance with the requirements of Iowa Code section 527.5(8).

*e. Validation.* A central routing unit must validate and edit all transaction messages flowing through the electronic funds transfer system to ensure transaction integrity.

*f. Error recovery.* A central routing unit must be responsible for error recovery of all of the central routing unit's owned or controlled hardware, software, and communication facilities and define all necessary interface requirements for data processing centers, satellite terminals, and financial institutions.

*g. Authorization services.* A central routing unit shall provide authorization services for all cardholder financial institutions that have agreed to such authorization services if:

(1) The cardholder financial institution's data processing center is unavailable or is responding slowly; or

(2) The cardholder financial institution's cardholder information is retained at the central routing unit for card authorization services.

*h. Third-party audits.* Third-party audits of an electronic funds transfer system, including a central routing unit, must be conducted at least annually to ensure adequate security and controls and be documented for review by the administrators upon request.

*i. Duplication of critical processing hardware.* A central routing unit must provide duplication of critical processing hardware to ensure functional integrity of the central routing unit.

*j. Electronic funds transfer system reliability standards.* A central routing unit must be available for processing transactions 99 percent of the time, on an annual basis, during the schedule of operation established by the central routing unit. To provide this continuous service to cardholders and the respective cardholder financial institution, a central routing unit must provide for data processing

center backup service for all cardholder financial institutions that utilize a data processing center. This may be accomplished by either of the following:

(1) Cardholder financial institutions may maintain a cardholder authorization file at the central routing unit; or

(2) A central routing unit may authorize transactions based on a cardholder financial institution's established parameters when the cardholder financial institution's data processing center is responding slowly or is in an inoperative state.

*k. Confidentiality.*

(1) A central routing unit shall not divulge specific transaction information to any person or financial institution concerning any cardholder, or an establishing or cardholder financial institution, unless such person or financial institution is part of, or is necessary to effect, the specific transaction, or unless disclosure of such information is required by applicable state or federal law.

(2) A central routing unit shall not divulge any statistics on the operations of any establishing or cardholder financial institution to any third party without the written consent of the particular financial institution.

(3) A central routing unit may disclose total terminal statistics that are generic to the central routing unit and that do not identify any particular financial institution or the operations of any particular financial institution.

(4) A central routing unit may disclose transaction(s) data to any federal or state regulatory authority as required by law.

**10.4(3)** *Certification processes of a central routing unit to demonstrate compliance.* To assist the administrators with compliance examinations of a central routing unit, a central routing unit shall certify financial institutions, satellite terminals located in the state, and data processing centers directly connected to the central routing unit located in this state or directly connected to cardholder financial institutions, to demonstrate that satellite terminals located in this state and the central routing unit are performing in accordance with the requirements of Iowa Code sections 527.5 and 527.9.

*a. Certification of financial institutions.* All establishing financial institutions and their data processing centers must comply with the following procedures, which shall be confirmed and certified by a central routing unit:

(1) The establishing financial institution and its data processing center must ensure that all transaction data transmitted by the establishing financial institution's data processing center conforms to the central routing unit's electronic communication format standards.

(2) The establishing financial institution's data processing center must be certified or recertified to support new terminal types or models, to utilize any new satellite terminal vendor, or to perform terminal hardware upgrades or software version updates, prior to actual transmission of transaction data by that data processing center to the central routing unit.

(3) Use of any satellite terminal located in this state must be available to all cardholders of cardholder financial institutions and other establishing financial institutions on a nondiscriminatory basis. A cardholder financial institution has the right to offer its cardholders any type of transaction that is supported by a central routing unit. Establishing financial institutions must offer to all cardholders of any establishing or cardholder financial institution the same type of transactions at their satellite terminals located off the premises of the establishing financial institution as are offered to cardholders of the establishing financial institution.

(4) An electronic personal identifier must be issued by a cardholder financial institution for each cardholder access device. A central routing unit must provide for cardholder entry of the electronic personal identifier for all transactions transmitted to the central routing unit. The requirement to issue an electronic personal identifier is not applicable to access devices that are only for use at a limited function terminal, as defined by Iowa Code section 527.2.

(5) A central routing unit must approve access devices displaying its logo or trade name that are issued by cardholder financial institutions, including any access devices that are redesigned, so that

the central routing unit may control the operational quality of the access devices and ensure uniform implementation of changes of such access devices.

(6) A control record must be maintained by a central routing unit for every satellite terminal deployed by an establishing financial institution that participates with the central routing unit.

(7) The establishing financial institution's data processing center must be responsible for forwarding transactions it cannot authorize or reject to a central routing unit for further routing. The establishing financial institution's data processing center must set a timer for that particular transaction at the time the transaction is forwarded to the central routing unit. If the establishing financial institution's data processing center does not receive a transaction transmission response from the central routing unit within the time frames established by the central routing unit, then the establishing financial institution's data processing center must immediately generate and transmit a reversal for that particular transaction. The cardholder financial institution's data processing center must accept the reversal from a central routing unit and the cardholder financial institution must post valid reversals to the cardholder's customer asset account. To monitor such reversals, a central routing unit must log each transaction routed through the central routing unit, validate each transaction's completion, and ensure that all transactions are sent to and received by the appropriate data processing centers for both the cardholder financial institution and the establishing financial institution.

(8) A central routing unit must certify all satellite terminals (whether switch-in-front or switch-behind) that an establishing financial institution proposes to use in conjunction with the central routing unit. This certification process shall test each satellite terminal for its ability to satisfactorily perform all transaction functions supported by the central routing unit in accordance with operational standards for satellite terminals as established by the central routing unit.

(9) An establishing financial institution must ensure that each of its satellite terminals provides a record of all approved or denied transactions at the satellite terminal by either an audit journal or the creation of duplicate receipts held within the satellite terminal and ensure that the satellite terminal generates a customer receipt in compliance with 12 CFR 205.9 (Regulation E) and requirements established by the central routing unit.

(10) Proper maintenance and service of satellite terminals on both a regular and emergency basis are the responsibilities of the establishing financial institution.

*b. Certification of data processing centers.* All data processing centers connected to a central routing unit must comply with the following procedures and requirements, to be confirmed by a central routing unit:

(1) A data processing center shall operate in such a manner as to comply with all requirements established in Iowa Code chapter 527.

(2) A data processing center shall conform to a central routing unit's standards including but not limited to the following:

1. Format and message content.
2. Electronic personal identifier encryption.
3. Communications protocol.
4. Certification of on-line transaction transmissions for data processing centers, new terminals, and all establishing and cardholder financial institutions directly or indirectly connected to the central routing unit.

(3) A data processing center must meet minimum response time goals established by a central routing unit. Satellite terminal transactions shall be handled on a first-in, first-out basis. No data processing center may prioritize satellite terminal transactions.

(4) A satellite terminal located in this state shall directly connect to a central routing unit or a data processing center. A data processing center or central routing unit is directly connected to a satellite terminal, as required by Iowa Code section 527.5(8), when a transaction transmission from the satellite terminal is received by the data processing center or central routing unit prior to being received or processed by or routed to any other data processing center or facility that categorizes, separates or routes the transaction transmission. A data processing facility certified by a central

routing unit and a front-end processor directly connected to an on-line point-of-sale satellite terminal and directly linked to the data processing facility both constitute a data processing center for purposes of this paragraph.

(5) This subrule does not limit the authority of a data processing center to authorize or reject transactions requested by cardholders of a cardholder financial institution pursuant to an agreement whereby the data processing center authorizes or rejects requested transactions on behalf of the cardholder financial institution and provides to the cardholder financial institution, on a batch basis and not on an on-line real-time basis, information concerning authorized or rejected transactions of cardholders of the cardholder financial institution.

*c. Nonsupport of a satellite terminal by a central routing unit.* A central routing unit has the authority to refuse or discontinue support of any satellite terminal (either switch-in-front or switch-behind) that is not established or maintained by the establishing financial institution in accordance with the certification procedures and requirements of this subrule if the central routing unit reasonably determines that initial or continued support of the noncomplying satellite terminal may jeopardize the safety and soundness of the operation of an electronic funds transfer system. If such action is contemplated by a central routing unit, written notice of the intended action and the reasons for not supporting particular satellite terminals shall be sent by the central routing unit to the appropriate establishing financial institution by certified or restricted certified mail, with a copy provided to the administrator, within 30 days of the date such action to discontinue support is to be taken, or within 10 days from the date the central routing unit determines it appropriate to refuse initial support of a newly established satellite terminal.

*d. Appeals to division administrator.*

(1) Whenever a central routing unit provides notice concerning the nonsupport of any satellite terminal located in the state upon the determination that the satellite terminal will not be, or is not being, maintained by the establishing financial institution in accordance with the requirements of this subrule and Iowa Code chapter 527, the establishing financial institution has the right to file a written appeal to the administrator within 30 days from the date the central routing unit issued a written notice of such action. The written appeal shall set forth any facts in dispute and state the reasons why the decision of the central routing unit to refuse initial or continued support of its satellite terminal or terminals should be reversed by the administrator. If the establishing financial institution fails to file a written appeal to the administrator, the financial institution is deemed to have consented to the nonsupport of its satellite terminal or terminals by the central routing unit.

(2) The administrator shall conduct hearings and exercise any other appropriate authority conferred by Iowa Code sections 527.3 and 527.5 regarding the operation or control of a satellite terminal that a central routing unit has initially determined to be operating in a manner inconsistent with the requirements of this subrule and Iowa Code chapter 527.

(3) Upon appeal, the administrator may affirm, modify, or reverse the initial determination of a central routing unit that a satellite terminal located in Iowa is not being operated or controlled in accordance with the requirements of this subrule and Iowa Code chapter 527.

(4) In the event of consent by the establishing financial institution, or if upon the record made at the hearing the administrator affirms the initial determination of the central routing unit, the administrator may initiate proceedings to revoke the privilege of the establishing financial institution to continue operation and control of the satellite terminal or terminals determined to be in noncompliance in accordance with the procedures established in paragraph 10.4(3)“e,” or may deny the initial application to establish or operate such noncomplying satellite terminals in accordance with rule 187—10.5(527).

(5) If the initial determination of the central routing unit is either reversed or modified, the administrator shall document the reasons for determining that the satellite terminals in question comply with the requirements of this subrule and Iowa Code chapter 527 or why the initial determination of the central routing unit has been modified and shall deliver a copy of these findings to the establishing financial institution and the appropriate central routing unit. Any further

proceedings or hearings on the same subject matter are governed by the provisions of Iowa Code chapter 17A relating to contested cases.

*e. Revocation of privilege.*

(1) The administrator may revoke the approval to operate within the electronic funds transfer system as established in Iowa Code section 527.12 or for violations of the compliance procedures and standards established by this subrule. If the administrator does not have any direct authority over the facility because of the provisions of Iowa Code section 527.3, the administrator may revoke with respect to any financial institution over which the administrator does have direct authority the privilege to engage in transactions through or with that facility. With respect to revocation of the approval to operate a central routing unit, all of the administrators specified in Iowa Code section 527.3 may jointly participate. All references to the term “administrator” in this paragraph signify all of the administrators with respect to revocation of the approval to operate a central routing unit.

(2) The administrator has additional authority to cause such revocations as established in Iowa Code section 527.12.

(3) If a central routing unit or satellite terminal of an establishing financial institution is determined by the administrator to fail to comply with the requirements of Iowa Code chapter 527 or this subrule at the time of application to the administrator, then the application may be denied by the administrator without the need for notice or opportunity for hearing.

(4) A revocation by the administrator pursuant to this subrule is effective when ordered by the administrator, anything in Iowa Code chapter 17A to the contrary notwithstanding.

(5) The administrator may bring an action in the district court in the name of the state to enjoin any financial institution or other person who continues to utilize or to operate a satellite terminal, data processing center, or central routing unit after approval has been revoked.

(6) The administrator may bring an action to enjoin any person who fails to obtain any approval required by Iowa Code chapter 527.

This rule is intended to implement Iowa Code chapter 527.

**187—10.5(527) Applications to establish a satellite terminal.**

**10.5(1) *Approval required.*** A satellite terminal shall not be established or operated in the state of Iowa unless written approval for that establishment and operation has been obtained from the administrator. Exceptions to this requirement may exist based upon judicial rulings on applicability of Iowa Code section 527.5(3) and 527.5(7) to certain federally chartered financial institutions.

**10.5(2) *Application requirements.*** A person desiring to establish and operate a satellite terminal shall submit to the administrator an application that shall contain all of the information and be accompanied by all documentation expressly provided for in Iowa Code section 527.5(3).

**10.5(3) *Incomplete applications.*** If the application is found by the administrator to be incomplete, the applicant will be notified within a reasonable period of that fact and of the specific deficiencies. Anytime after 30 days following any such notification, the application may be denied for lack of information if requested supplemental information is not timely submitted by the applicant.

**10.5(4) *Final notice.*** Upon receiving a complete application, the administrator shall approve or disapprove an application for the establishment and operation of a satellite terminal within 30 days after the date of written notice to the applicant that the application is determined to be complete. The administrator shall notify the applicant in writing as to the decision to approve or disapprove.

**10.5(5) *Failure to establish.*** If the applicant fails to establish a satellite terminal within 60 days after the date of written notification of approval by the administrator or within 90 days of filing of the application if such notice is not given by the administrator and expressed approval is presumed, the application to establish and operate a satellite terminal in this state shall be considered to be withdrawn by the applicant and the satellite terminal shall not be established and operated in Iowa without reapplication or extension of the application period by the administrator.

**10.5(6) *Notice to terminate satellite terminal operation.*** If an establishing financial institution determines, for whatever reasons, that a satellite terminal it operates shall no longer be made available

for continued use in the state of Iowa, written notice of such termination of service shall be provided to the administrator, with a copy to the central routing unit, at least 15 business days prior to such discontinuance of service.

This rule is intended to implement Iowa Code section 527.5(7).

**187—10.6(527) Customer instruction in the use of a satellite terminal.** Iowa Code section 527.5(4) permits employees of the establishing financial institution or an affiliate to attend or operate a satellite terminal, for specified purposes, on a temporary basis, and such temporary basis extends no more than 30 calendar days from the date of initial operation of the satellite terminal. Satellite terminals located on the premises of the establishing financial institution are exempt from this restriction.

This rule is intended to implement Iowa Code section 527.5(4).



## ARC 0303D

**HUMAN SERVICES DEPARTMENT[441]****Notice of Intended Action****Proposing rulemaking related to uniform rules on agency procedure  
and providing an opportunity for public comment**

The Department of Health and Human Services hereby proposes to amend Chapter 9, “Public Records and Fair Information Practices,” and to adopt new Chapter 2504, “Rule Waivers,” Chapter 2505, “Fair Information Practices,” and Chapter 2506, “Contested Cases,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in 2026 Iowa Acts, Senate File 2463.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, 2026 Iowa Acts, Senate File 2463.

*Purpose and Summary*

This proposed rulemaking rescinds rules 441—9.2(17A,22) and 441—9.12(17A,22), which were not automatically rescinded under the provisions of 2026 Iowa Acts, Senate File 2463.

These amendments also modify the Uniform Rules on Agency Procedure related to rule waivers (Chapter 2504), fair information practices (Chapter 2505) and contested cases (Chapter 2506) to maintain rules as determined necessary by the Department and to ensure that the Department follows all applicable State and federal requirements not currently contained in the Uniform Rules on Agency Procedure.

The reasons for the Department’s additions, exceptions, or amendments to the rules under agency number [7] are detailed below.

**Rule waivers (441—Chapter 2504):**

- Did not adopt language from 7—subrule 2504.3(2) allowing an evidentiary hearing on the denial of a request for waiver. Iowa Code section 17.9A(2) provides that determinations on waivers are within the sole discretion of an agency and therefore would not properly be raised before an administrative law judge (ALJ).

**Fair information practices (441—Chapter 2505):**

- Added definitions in rule 441—2505.1(17A,22) necessitated by the new rule content described below.
- Added new subrule 2505.5(4), which provides that individuals may request restrictions on the use of protected health information (PHI) pursuant to 45 CFR 164.522.
- Added new subrule 2505.7(1) relating to disclosures of PHI allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Added new subrule 2505.7(2) specifying that the Department will also maintain written policies for general uses of PHI for treatment, payment, and health care operations pursuant to HIPAA.
- Added new rule 441—2505.9(22,252G) to restore the provisions of rule 441—9.12(17A,22), which was allowed to be retained by the Department under the provisions of 2026 Iowa Acts, Senate File 2463.

**Contested cases (441—Chapter 2506):**

- Added definitions to rule 441—2506.2(17A) that pertain to subsequent additions to the Uniform Rules on Agency Procedure.
- Replaced language of subrule 2506.3(1) pertaining to time computation with more specific provisions to account for time tolled for State holidays that is not accounted for in the Iowa Code section referenced in the Uniform Rules on Agency Procedure.

- Added subrule 2506.4(3) regarding “parties-in-interest” to a contested case. The Department frequently encounters situations in which a contested case hearing is requested by individuals who are not constitutionally or statutorily entitled to a hearing. Adding this subrule provides clear guidelines for those situations.

- Added subrule 2506.4(4) outlining situations in which a contested case hearing will not be granted by the Department.

- Added subrule 2506.4(5), which accounts for situations in which all other remedies must be exhausted before a contested case hearing will be granted. For example, under Medicaid managed care, aggrieved enrollees must first go through the internal grievance process established by the Managed Care Organizations (MCOs) prior to requesting a contested case hearing from the State.

- Added subrule 2506.4(6) to accommodate federal regulations for appeals under Medicaid and the Supplemental Nutrition Assistance Program (SNAP). These regulations outline the methods in which appeals can be submitted and encompass more than electronic submission, which is the only method allowed under the Uniform Rules on Agency Procedure.

- Added subrule 2506.4(7), which sets a standard time frame to file appeals for situations in which another law or rule does not set forth the time frame.

- Added subrule 2506.4(8) regarding acceptance or denial of an appeal. The Department receives approximately 10,000 appeal requests per year, many from unrepresented individuals. This provision allows the Department to vet the requests to determine whether they should move forward, facilitating efficiency, while still preserving an individual’s right to appeal.

- Added subrule 2506.4(9), which allows the Department to designate and certify exactly which issues are to be decided in the contested case proceeding. This creates clarity early in the process yet allows the issues to be adjusted as the appeal progresses. This provision is not included in the Uniform Rules on Agency Procedure.

- Added subrule 2506.4(10) to incorporate federal requirements for SNAP hearings.

- Added a revised subrule 2506.5(2), which excludes language from the Uniform Rules on Agency Procedure that the Department has already clarified by previously adding subrule 2506.4(7). This clearly establishes that the Department bears the burden of identifying the issues of the matter. In addition, the revised subrule excludes language that would require the Department to set forth the telephone number and address of all representatives, which would require a system change for the Department.

- Revised language in subrule 2506.6(1), which reflects the fact that almost all the Department’s appeals go before an ALJ and therefore parties would only have to request an ALJ in the event one has not already been assigned.

- Added subrules 2506.10(3) and 2506.10(4) to ensure compliance with federal regulations for Medicaid and SNAP appeals, respectively.

- Did not adopt rule 441—2506.11(17A), which would require a formal petition in addition to the request for contested case hearing and would also require the Department to answer every appeal. Due to the Department’s high volume of appeals and current appeals system constraints, the requirements of this rule would be overly burdensome.

- Added conforming language to subrule 2506.12(1) to reflect the Department’s addition of subrule 2506.4(4) regarding filing methodology. This addition ensures compliance with federal Medicaid regulations.

- Added subrule 2506.18(1), which conforms to the federal regulations that dictate method of withdrawal from Medicaid appeals.

- Added subrule 2506.18(2), which conforms to the federal regulations that dictate method of withdrawal from SNAP appeals.

- Added language to subrule 2506.20(3) to explicitly state that:

- The Department may be represented by its own employees or employees of Department contractors at contested case hearings.

- Medicaid members may appoint an authorized representative to represent them in all Department matters as required by 42 CFR 435.923.

- Added subrule 2506.20(8) to help ensure that the terms of authorized representation are clearly defined and properly limited to protect Medicaid members' interests.
- Added subrule 2506.20(9) to require legal counsel to enter an appearance. Because the Department does not require petitions and answers, requiring counsel to enter an appearance is necessary to ensure the Department is aware of representation.
- Added subrule 2506.20(10), which provides that absent a mutual agreement by the parties, contested case hearings are closed to the public. This is necessary because many of the Department's appeals pertain to sensitive, confidential situations and information.
- Added paragraphs 2506.27(1)"a" through "e" to reflect the unique time frames required by State or federal law for Medicaid, SNAP, child abuse, and the Special Supplemental Nutrition Program for Women and Children (WIC) appeals of proposed decisions.
- Added the qualifier, "Unless otherwise required by law," to subrule 2506.27(2) to reflect the time frames described in subrule 2506.27(1).
- Added subrule 2506.27(7) to maintain the Department's existing requirement that a director's review on appeal is limited to the issues and record heard by the ALJ.
- Added rule 441—2506.32(17A) to implement federal requirements for the time frames within which contested cases must be held for Medicaid, division of spousal community resources for benefit determinations; SNAP; and WIC.
- Added rule 441—2506.33(17A) to reflect the federal requirements for an expedited review for Medicaid appeals.
- Added rule 441—2506.34(17A) to account for the federal requirements for administrative disqualifications hearings with respect to SNAP.
- Added rule 441—2506.35(17A) containing federal requirements for continuation and reinstatement of benefits in certain circumstances and allowing the Department to recoup benefits in the event an adverse action is overturned.

#### *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 2504.

#### *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 June 16, 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](mailto:compliancerules@hhs.iowa.gov)

*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).

*Emergency Rulemaking Adopted by Reference*

This proposed rulemaking is also published herein as an Adopted and Filed Emergency rulemaking (see **ARC 0300D**, IAB 05/27/26). The purpose of this Notice of Intended Action is to solicit public comment on that emergency rulemaking, whose subject matter is hereby adopted by reference.

**ARC 0301D****HUMAN SERVICES DEPARTMENT[441]****Notice of Intended Action****Proposing rulemaking related to social casework  
and providing an opportunity for public comment**

The Department of Health and Human Services hereby proposes to rescind Chapter 131, “Social Casework,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Executive Order 10.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 234.

*Purpose and Summary*

Chapter 131 underwent a Red Tape Review pursuant to Executive Order 10. As a result, the Department determined the chapter was largely duplicative of 441—Chapter 130, which is being addressed in a separate proposed rulemaking.

*Regulatory Analysis*

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on April 15, 2026. A public hearing was held on the following date(s):

- May 5, 2026

*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 2504.

*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 June 16, 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](mailto:compliancerules@hhs.iowa.gov)

*Public Hearing*

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

|                                   |                                                                          |
|-----------------------------------|--------------------------------------------------------------------------|
| June 16, 2026<br>10 to 10:30 a.m. | Microsoft Teams<br>Meeting ID: 263 169 532 452 86<br>Passcode: mw3az6Y4  |
| June 16, 2026<br>2 to 2:30 p.m.   | Microsoft Teams<br>Meeting ID: 291 791 691 067 154<br>Passcode: aM7kF7Da |

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Department and advise of specific needs.

*Review by Administrative Rules Review Committee*

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind and reserve **441—Chapter 131**.

**ARC 0302D**

**HUMAN SERVICES DEPARTMENT[441]****Notice of Intended Action**

**Proposing rulemaking related to in-home health-related care  
and providing an opportunity for public comment**

The Department of Health and Human Services hereby proposes to rescind Chapter 177, “In-Home Health-Related Care,” Iowa Administrative Code, and to adopt a new Chapter 177 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Iowa Code section 249.3(2).

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code section 249.3(2).

*Purpose and Summary*

The purpose of this proposed rulemaking is to describe the In-Home Health-Related Care program, which is designed to provide in-home nursing care to an individual whose physical, developmental, or mental health prevents independent self-care. The provider, who is usually a relative, is certified by a physician, and the program dollars are optimized by not paying a higher rate charged by an agency.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result, the Department standardized terminology, removed provisions that were no longer valid, and reduced restrictive terms.

The Department also changed the certification period from once every 180 days to once every 365 days.

*Regulatory Analysis*

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on April 15, 2026. A public hearing was held on the following date(s):

- May 5, 2026

*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 2504.

*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 June 16, 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](mailto:compliancerules@hhs.iowa.gov)

*Public Hearing*

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

June 16, 2026  
10 to 10:30 a.m.

Microsoft Teams  
Meeting ID: 263 169 532 452 86  
Passcode: mw3az6Y4

June 16, 2026  
2 to 2:30 p.m.

Microsoft Teams  
Meeting ID: 291 791 691 067 154  
Passcode: aM7kF7Da

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

CHAPTER 177  
IN-HOME HEALTH-RELATED CARE

**441—177.1(249) Definitions.**

*“Nursing care”* includes skilled services and personal care services.

*“Own home”* means an individual's house, apartment, or other living arrangement intended for single or family residential use.

*“Personal care services”* includes:

1. Services that assist a client with the activities of daily living, such as but not limited to helping the client with bathing, toileting, getting in and out of bed, ambulation, hair care, oral hygiene and administering medications that are physician-ordered but ordinarily self-administered.
2. Services that help or retrain the client in necessary skills for daily living.
3. Incidental household services that are essential to the client's health care at home and are necessary to prevent or postpone institutionalization.

*“Skilled nursing services”* are services for which an individualized assessment of a patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse (skilled care) are necessary.

*“Skilled services”* include skilled nursing services or other services that, based on a physician's certification, are required to be performed under the supervision of a physician, nurse practitioner, clinical nurse specialist, or physician associate.

*“Supervising practitioner”* means a physician, nurse practitioner, clinical nurse specialist, or physician associate qualified to supervise skilled services.

**441—177.2(249) Eligibility and application.**

**177.2(1) Eligibility.** To be eligible for in-home health-related care (IHHRC):

- a. The individual must be eligible for supplemental security income (SSI) in every respect, except for income.
- b. A physician must certify in accordance with rule 441—177.5(249) that the individual requires either skilled services or personal care services and that those services can be provided in the individual's own home. The certification shall be provided using a form prescribed by the department.

c. The individual shall live in the individual's own home. Notwithstanding the foregoing, an individual will remain eligible for a period not to exceed 15 days in any calendar month when the client is temporarily absent from the client's home.

d. The individual shall obtain a physical examination report annually and shall be under the supervision of a physician.

e. The required skilled services or personal care services must not be available under any other state or federal program.

f. The countable income of the individual and spouse living in the home shall be limited to \$480.55 per month if one needs care or \$961.10 if both need care, after the following disregards from gross income:

- (1) The amount of the basic SSI standard for an individual or a couple, as applicable.
- (2) When income is earned, \$65 plus one-half of any remaining income.
- (3) The amount of the SSI standard for a dependent plus any established unmet medical needs for each dependent living in the home. Any income of the dependent shall be applied to the dependent's needs before making this disregard.

(4) The amount of the established medical needs of the ineligible spouse that are not otherwise met.

(5) The amount of the established medical needs of the applicant or recipient that are not otherwise met and would not be met if the individual were eligible for the medical assistance program.

g. Income for children.

(1) All income received by the parents in the home shall be deemed to the child with the following disregards:

1. The amount of the basic SSI standard for an individual when there is one parent in the home or for a couple when there are two parents in the home.

2. The amount of the basic SSI standard for a dependent for each ineligible child in the home.

3. The amount of the unmet medical needs of the parents and ineligible dependents.

4. When all income is earned, an additional basic SSI standard for an individual in a one-parent home or for a couple in a two-parent home.

5. When the income is both earned and unearned, \$65 plus one-half of the remainder of the earned income.

(2) The countable income of the child shall be limited to \$480.55 per month after the following disregards from gross income:

1. The amount of the basic SSI standard for an individual.

2. The amount of the established medical needs of the child that are not otherwise met and would not be met if the child were eligible for the medical assistance program.

3. One-third of the child support payments received from an absent parent.

**177.2(2) Application.** Application for IHHRC shall be made on a form prescribed by the department and submitted to the department. An eligibility determination will be completed within 30 days from the date of the application unless one or more of the following conditions exist:

a. An application has been filed and is pending for federal SSI benefits.

b. The application is pending because the department has not received information that is beyond the control of the client or the department.

c. The application is pending due to the disability determination process performed through the department.

d. The application is pending because the provider agreement has not been completed and completion is beyond control of the client. When the provider agreement cannot be completed due to the client's failure to locate a provider, applications will not be held pending beyond 60 days from the date of application.

#### **441—177.3(249) Qualifications of providers of health care services.**

**177.3(1) Age.** The provider shall be at least 18 years of age.



**177.3(2) *Health assessment.*** The provider shall obtain certification on a form prescribed by the department that the provider is physically and emotionally capable of providing assistance to another person whose physical, developmental or mental health prevents independent self-care.

*a.* The certification shall be based on an examination performed by:

(1) A physician; or

(2) An advanced registered nurse practitioner or physician associate if the advanced registered nurse practitioner or physician associate is working under the direction of a physician.

*b.* If the provider works for an agency, the practitioner performing the examination may not be employed by the same agency.

*c.* The practitioner conducting the examination shall sign the certification.

*d.* The certification shall be submitted to the department:

(1) Before the provider agreement is signed, and

(2) Annually thereafter.

**177.3(3) *Qualifications.*** The provider shall be qualified by training and experience to carry out the health care plan as specified in subrule 177.6(1).

**177.3(4) *Relative.*** The provider may be related to the client, so long as the provider is not the client's:

*a.* Legal spouse, including a common law spouse, who resides in the same household.

*b.* Natural mother or father, adoptive mother or father, or stepmother or stepfather, who resides in the same household.

**441—177.4(249) Physician's certification.**

**177.4(1) *Certification requirements.*** A physician must certify on a form provided by the department:

*a.* That the skilled services or personal care services are required by the person's physical, developmental or mental health;

*b.* The specific skilled services or personal care services required, the method of providing those services, and the expected duration of those services; and

*c.* That the required skilled services and personal care services can be delivered in the individual's own home.

**177.4(2) *Certification review.*** After certification and any subsequent recertification, a physician must review the certification and withdraw, renew, or amend the existing certification:

*a.* No later than the three hundred sixty-fifth day after the existing certification;

*b.* More frequently than yearly after the existing certification if required by the physician, the department, or a supervising practitioner; or

*c.* Upon notification of initiation of Medicaid waiver services.

**441—177.5(249A) Department duties.**

**177.5(1) *Service plan.***

*a.* In consultation with the client's case manager and any supervising health practitioner, the department will create a complete service plan for the client. The plan must avoid duplication of services and include all of the following:

(1) All of the services certified by a physician under rule 441—177.4(249).

(2) Payer sources. IHRC care shall be provided only when other programs cannot meet the client's needs.

(3) Level of service needs.

(4) Service history. If the client is being transferred from a medical hospital or long-term care facility, the department will also obtain a transfer document describing the client's current care plan.

*b.* In consultation with the client's case manager and any supervising health practitioner, the department will review and update the service plan on or before the ninetieth day following the creation of or previous review of the service plan. The updated service plan must comply with paragraph 177.5(1) "a."

**177.5(2) *Change in condition.*** If the department becomes aware of any changes in the individual's condition, including discharge from a facility, that could require a change in the services provided, the department will ensure that a physician reviews the existing certification and that the existing certification is withdrawn, renewed, or amended.

**177.5(3) *Service documentation.***

- a.* The department will review the service documentation submitted by the client or provider, including any requests for supplementation of services.
- b.* If there are concerns as a result of such a review, there will be a change in the service plan.

**441—177.6(249) Supervising practitioner duties.**

**177.6(1) *Instruction.*** The supervising practitioner shall provide instruction specific to each patient and the services each patient is receiving, including but not limited to instruction on documentation the worker should be creating and instruction on warning signs of which the department should be aware.

**177.6(2) *Schedule for reviewing documentation.*** The supervising practitioner shall set up a schedule for reviewing documentation that is specific to the services being provided to that particular patient and shall review the documentation according to the schedule.

**177.6(3) *Medical records.***

- a.* The supervising practitioner shall keep appropriate medical records, a copy of the service plan, and the physician's certification in the supervising practitioner's case file. In addition, the medical records shall include, whenever appropriate, transfer forms, physician's orders, progress notes, drug administration records, treatment records, and incident reports.
- b.* The supervising practitioner shall make all medical records available to the department, the client, and the client's legal representative.
- c.* The supervising practitioner shall ensure that, upon termination of the in-home care plan, the medical records are transferred to the department.
- d.* The department will retain medical records transferred to it under paragraph 177.6(3) "c" for five years or, if an audit is commenced within the five years, until completion of that audit.

**441—177.7(249) Written agreements.**

**177.7(1) *Independent contractor.*** The provider shall be an independent contractor and shall not be an agent, employee or servant of the state of Iowa, the department or any of its employees or clients.

**177.7(2) *Liability coverage.*** All professional health care providers shall have adequate liability coverage consistent with the professional health care providers' responsibilities, since the department assumes no responsibility, or liability, for individuals providing care.

**177.7(3) *Provider agreement.***

- a.* The client and the provider shall enter into an agreement using a form prescribed by the department prior to the provision of service. Any reduction to the state supplemental assistance program shall be applied to the maximum amount paid by the department as stated in the provider agreement by using the separate amendment to provider agreement form.
- b.* Written instructions for dealing with emergency situations will be completed by the department and included in the provider agreement, which shall be maintained in the client's home and at the department. The instructions will include:
  - (1) The name and telephone number of the client's physician, responsible family members or other significant persons;
  - (2) Information as to which hospital to utilize; and
  - (3) Information as to which ambulance service or other emergency transportation to utilize.

**441—177.8(249) Payment.**

**177.8(1) *Payment approved.*** Notwithstanding 42 U.S.C. §1382(c)(7) as amended to August 1, 2026, after the department approves the service plan, payment is effective as of the later of (1) the date of the application or (2) the date all eligibility requirements are met and qualified health care services are provided.

**177.8(2) *Client participation.***

a. Except as provided in paragraph 177.8(2) “b,” all income remaining after excluding the amounts identified in paragraphs 177.2(1) “f” and “g” will be considered income available for services (client participation) and the IHHRC program will pay only the cost of eligible services that exceeds client participation up to the maximum benefit payable.

b. When the first month of service is less than a full month, there is no client participation for that month. Payment will be made for the actual days of service provided according to the agreed-upon rate up to the maximum benefit payable.

**177.8(3) Maximum benefit payable.** The maximum benefit payable for IHHRC services inclusive of all services for all providers is the reasonable charges for such services up to and including \$480.55. The provider shall accept the maximum benefit payable and shall not charge the client or others in excess of that benefit.

**177.8(4) Payment.** The client or the person legally designated to handle the client’s finances shall be the sole payee for payments made under the program and shall be responsible for making payment to the provider except when the client payee becomes incapacitated or dies while receiving service.

a. The department will have the authority to issue one payment to a provider on behalf of a client payee who becomes incapacitated or dies while receiving service.

b. When continuation of an incapacitated client payee in the program is appropriate, the department will assist the client and the client’s family to legally designate a person to handle the client’s finances. Guardians, conservators, protective or representative payees, or persons holding financial power of attorney are considered to be legally designated.

c. If the client has a temporary absence from home, payment will not be authorized for over 15 days for any continuous absence whether or not the absence extends into a succeeding month or months.

**177.8(5) Reasonable charges.** Payment will be made only for reasonable charges for in-home health care services as determined by the department, which will determine reasonableness by:

a. The prevailing community standards for cost of care for similar services.

b. The availability of services at no cost to the IHHRC program.

**441—177.9(249) Termination conditions.** Termination of IHHRC will occur under the following conditions.

**177.9(1) Request.** When the client or the client’s legal representative requests termination.

**177.9(2) Care unnecessary.** When the client becomes sufficiently able to remain in the client’s own home with services that can be provided by other sources as determined by the department.

**177.9(3) Additional care necessary.** When 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 department in consultation with the certifying physician.

**177.9(4) Excessive costs.** When the cost of care exceeds the maximum established in subrule 177.9(3).

**177.9(5) Other services utilized.** When the department determines that other services can be utilized to better meet the client’s needs.

**177.9(6) Terms of provider agreement not met.** When it has been determined by the department that the terms of the provider agreement have not been met by the client or the provider, the state supplementary assistance payment may be terminated.

**177.9(7) Failing to comply with program requirements.** When the recipient is not following the program requirements or cooperating with the program objectives, including but not limited to a failure to provide documentation to program representatives.

**177.9(8) Notice and appeal.** Written notice of termination will be provided pursuant to 441—Chapter 16. The decision may be appealed pursuant to 441—Chapter 2506.

These rules are intended to implement Iowa Code section 249.3(2) “a”(2).

**ARC 0324D****INSPECTIONS AND APPEALS DEPARTMENT[481]****Notice of Intended Action****Proposing rulemaking related to licensure of speech pathologists  
and audiologists and providing an opportunity for public comment**

The Board of Speech Pathology and Audiology hereby proposes to amend Chapter 740, “Licensure of Speech Pathologists and Audiologists,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Iowa Code chapters 147F and 154F and sections 272C.3 and 272C.10.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapters 17A, 147, 147F, 154F and 272C.

*Purpose and Summary*

The proposed amendments define the requirements for participation in the Audiology and Speech-Language Pathology Interstate Compact, add background check requirements for all applicants and existing license holders, add background check requirements during license reactivation when a license has been inactive for two or more years and the licensee cannot provide evidence of active practice in another state, add a fee for the issuance of a compact privilege to practice in Iowa, and waive the compact privilege fee for an active duty military member or spouse.

*Regulatory Analysis*

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on February 18, 2026. A public hearing was held on the following date(s):

- March 10, 2026

*Fiscal Impact*

This rulemaking has no fiscal impact to the State of Iowa.

*Jobs Impact*

After analysis and review of this rulemaking, no impact on jobs has been found.

*Waivers*

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any, pursuant to 481—Chapter 6.

*Public Comment*

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Board no later than 4:30 p.m. on June 16, 2026. Comments should be directed to:

Venus Vendoures Walsh  
Department of Inspections, Appeals, and Licensing  
6200 Park Avenue, Suite 100

Des Moines, Iowa 50321  
Phone: 515.242.6529  
Fax: 515.281.7969  
Email: [venus.vedoures-walsh@dia.iowa.gov](mailto:venus.vedoures-walsh@dia.iowa.gov)

### *Public Hearing*

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

|                     |                                                                                                                   |
|---------------------|-------------------------------------------------------------------------------------------------------------------|
| June 16, 2026       | Via Google Meet                                                                                                   |
| 11:30 to 11:55 a.m. | <a href="https://meet.google.com/rnt-jopx-bwj">meet.google.com/rnt-jopx-bwj</a>                                   |
|                     | Or dial: 1.470.242.8058                                                                                           |
|                     | PIN: 368 712 505#                                                                                                 |
|                     | More phone numbers: <a href="tel:meet/rnt-jopx-bwj?pin=5520965799206">tel.meet/rnt-jopx-bwj?pin=5520965799206</a> |

Persons who wish to make oral comments at the 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 the public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Board 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 rule **481—740.1(147)**, definitions of “Reactivate” and “Speech pathologist,” as follows:

“*Reactivate*” or “*reactivation*” means the process as outlined in rule ~~481—740.11(17A,147,272C)~~ 481—740.10(17A,147,272C) by which an inactive license is restored to active status.

“*Speech pathologist*” or “*speech-language pathologist*” means a person who engages in the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, rehabilitation, or remediation related to the development and disorders of speech, swallowing, fluency, voice, or language for the purpose of nonmedically evaluating, preventing, ameliorating, modifying, or remediating such disorders and conditions in individuals or groups of individuals.

ITEM 2. Adopt the following **new** definitions of “DCI,” “Department” and “FBI” in rule **481—740.1(147)**:

“*DCI*” means the Iowa division of criminal investigation.

“*Department*” means the department of inspections, appeals, and licensing.

“*FBI*” means the Federal Bureau of Investigation.

ITEM 3. Rescind rule 481—740.2(147) and adopt the following **new** rule in lieu thereof:

**481—740.2(147) Initial licensure.** The following criteria will apply to licensure:

**740.2(1)** Applicants will submit a completed online licensure application and pay the nonrefundable licensure fee specified in rule 481—507.20(147,154F).

**740.2(2)** Application requirements.

*a.* Applicants who did not complete the nine months of clinical experience under supervision of a licensed Iowa speech pathologist or audiologist, as appropriate, must submit:

- (1) An official copy of a current ASHA certificate of clinical competence; or
- (2) Verification of current ABA certification.

b. Applicants who complete the nine-month clinical experience under Iowa supervision may submit evidence of licensure requirements as outlined in paragraph 740.2(2)“a” or must submit the following:

- (1) Official copies of academic transcripts sent directly from the school to the board showing proof of completion of not less than 400 hours of supervised clinical training; and
- (2) Verification of nine months of full-time clinical experience, or equivalent, completed after the master’s degree, under the supervision of a licensed speech pathologist or audiologist or as a part of the doctoral degree.

c. Results of the Praxis Examination.

**740.2(3)** Applicants will submit required waivers and fingerprints pursuant to the board-approved process to facilitate a national criminal history background check by the DCI and the FBI. The cost of the criminal history background check by the DCI and the FBI shall be assessed to the applicant.

**740.2(4)** An applicant who has been licensed in the District of Columbia or another state, territory, province or foreign country who has been a licensed speech pathologist or audiologist under the laws of another jurisdiction will provide verification of license from the jurisdiction in which the applicant has most recently been licensed sent directly from the jurisdiction to the board office. The applicant must also disclose any public or pending complaints against the applicant in any other jurisdiction. Web-based verification may be substituted for verification direct from the jurisdiction’s board office if the verification provides:

- a. Licensee’s name;
- b. Date of initial licensure;
- c. Current licensure status; and
- d. Any disciplinary action taken against the license.

**740.2(5)** An applicant who has relocated to Iowa from a state that did not require licensure to practice the profession may submit proof of work experience in lieu of educational and training requirements, if eligible, in accordance with rule 481—501.2(272C).

**740.2(6)** If the application is not completed according to the instructions, the application will not be reviewed by the board.

ITEM 4. Rescind subrule 740.3(2) and adopt the following **new** subrule in lieu thereof:

**740.3(2)** Foreign-trained applicants.

a. Foreign-trained speech pathologist and audiologist applicants who do not hold a license in another state or U.S. territory shall provide an English translation and an equivalency evaluation at the licensee’s expense of the licensee’s educational credentials by one of the approved credential evaluation services on ABA’s or ASHA’s websites or approved by the board. The professional curriculum must be equivalent to that stated in these rules.

b. Foreign-trained applicants who hold a license in another state or U.S. territory may apply for licensure by endorsement.

ITEM 5. Rescind rule 481—740.5(147) and adopt the following **new** rule in lieu thereof:

**481—740.5(147) Audiology and speech-language pathology interstate compact.** The rules of the audiology and speech-language pathology interstate compact commission are incorporated by reference pursuant to Iowa Code section 147F.1. An audiologist or speech-language pathologist may engage in the practice of audiology or speech-language pathology in Iowa without a license issued by the board if the individual has a current compact privilege to practice in Iowa issued by the audiology and speech-language pathology interstate compact commission. The state fee for issuance of a compact privilege to practice in Iowa shall be \$60, which will be collected by the speech-language pathology interstate compact commission. The state fee for issuance of a compact privilege to practice in Iowa shall be waived for an active-duty military member or spouse of an individual who is an active-duty military member. An audiologist or speech-language pathologist who practices audiology or speech-language pathology in Iowa using a compact privilege is subject to the rules governing licensees in

rule 481—740.8(147) and in 481—Chapters 741 and 743. Complaints, investigations, and disciplinary proceedings involving a compact privilege shall be handled in accordance with Iowa Code chapters 17A, 147F, 154F and 272C and with 481—Chapters 503, 504, and 506.

ITEM 6. Rescind rule **481—740.9(147)**.

ITEM 7. Amend paragraph **740.10(3)“a”** as follows:

a. Meet the continuing education requirements of rule 481—742.2(147) and the mandatory reporting requirements of subrule ~~740.10(4)~~ **740.9(4)**. A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

ITEM 8. Amend paragraph **740.10(4)“b”** as follows:

b. The board may select licensees for audit of compliance with the requirements in paragraphs ~~740.11(4)~~ **740.10(4)** “a” and “b.”

ITEM 9. Adopt the following **new** subrule 740.10(9):

**740.10(9)** Compact eligibility review. This rule applies to licensees who were licensed prior to enactment of this rule. In order to complete the compact eligibility review, at or prior to a licensee’s next renewal, the licensee must submit required waivers and fingerprints pursuant to the board-approved process to facilitate a national criminal history background check. The cost for the evaluation of the fingerprint packet and the DCI and the FBI criminal history background checks will be assessed to the applicant. The board may withhold issuing a license pending receipt of a report from the DCI and the FBI.

ITEM 10. Amend subparagraph **740.11(2)“a”(2)** as follows:

(2) Verification of completion of 26 hours of continuing education within two years of application for reactivation or verification of active practice, consisting of a minimum of 2,080 hours, in another state or jurisdiction during the two years preceding an application for reactivation.

ITEM 11. Amend subparagraph **740.11(2)“b”(2)** as follows:

(2) Verification of completion of 52 hours of continuing education within two years of application for reactivation or 26 hours of continuing education within two years of application for reactivation and verification of active practice, consisting of a minimum of 2,080 hours, in another state or jurisdiction during the two years preceding an application for reactivation; or

ITEM 12. Adopt the following **new** subrule 740.11(3):

**740.11(3)** If the license has been inactive for two or more years and the licensee cannot provide verification of active practice, consisting of a minimum of 2,080 hours, in another state or jurisdiction during the two years preceding an application for reactivation, the licensee must submit required waivers and fingerprints pursuant to the board-approved process to facilitate a national criminal history background check. The cost for the evaluation of the fingerprint packet and the DCI and the FBI criminal history background checks will be assessed to the applicant. The board may withhold issuing a license pending receipt of a report from the DCI and the FBI.

ITEM 13. Renumber rules **481—740.10(147)** to **481—740.12(17A,147,272C)** as **481—740.9(147)** to **481—740.11(17A,147,272C)**.

**ARC 0304D**

## **INSURANCE DIVISION[191]**

### **Notice of Intended Action**

**Proposing rulemaking related to licensing of public adjusters  
and providing an opportunity for public comment**

The Insurance Division hereby proposes to amend Chapter 55, “Licensing of Public Adjusters,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Iowa Code chapter 522C and 2026 Iowa Acts, House File 2582, section 4.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 522C as amended by 2026 Iowa Acts, House File 2582.

*Purpose and Summary*

This proposed rulemaking addresses the financial responsibility requirements for adjusters that had been set out in the Iowa Code and in the Insurance Division Bulletin. This proposed rulemaking allows for expanded methods by which adjusters may comply with the financial responsibility requirements. The financial responsibility requirements could be the subject of frequent adjustments; therefore, the rulemaking process affords greater flexibility in addressing such changes.

*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 Division for a waiver of the discretionary provisions, if any, pursuant to 191—Chapter 4.

*Public Comment*

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Division no later than 4:30 p.m. on June 16, 2026. Comments should be directed to:

Angela Burke Boston  
Iowa Insurance Division  
1963 Bell Avenue, Suite 100  
Des Moines, Iowa 50315  
Phone: 515.654.6543  
Fax: 515.654.6500  
Email: [angela.burke.boston@iid.iowa.gov](mailto:angela.burke.boston@iid.iowa.gov)

*Public Hearing*

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

June 16, 2026  
11 a.m. to 12 noon

1963 Bell Avenue, Suite 100  
Des Moines, Iowa

Persons who wish to make oral comments at the 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 the public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Angela Burke Boston via email at [angela.burke.boston@iid.iowa.gov](mailto:angela.burke.boston@iid.iowa.gov) or by telephone at 515.654.6543 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).

*Emergency Rulemaking Adopted by Reference*

This proposed rulemaking is also published herein as an Adopted and Filed Emergency rulemaking (see **ARC 0308D**, IAB 5/27/26). The purpose of this Notice of Intended Action is to solicit public comment on that emergency rulemaking, whose subject matter is hereby adopted by reference.

**ARC 0297D**

**RACING AND GAMING COMMISSION[491]**

**Notice of Intended Action**

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

The Racing and Gaming Commission hereby proposes to adopt new Chapter 2503, "Declaratory Orders—Modifications to Uniform Rules," and new Chapter 2506, "Contested Cases—Modifications to Uniform Rules," 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, 2026 Iowa Acts, Senate File 2463.

*Purpose and Summary*

Iowa Code section 17A.24 provides that if an agency does not have rules in effect covering certain procedural subjects, then the Uniform Rules on Agency Procedure adopted by the Administrative Rules Coordinator apply to the agency. The Administrative Rules Coordinator has adopted uniform administrative rules under agency [7].

2026 Iowa Acts, Senate File 2463, section 4, subsections 1(be) and (bf), legislatively rescind certain Commission rules effective July 1, 2026. Accordingly, under Iowa Code section 17A.24(2), the agency will not have rules in effect addressing the Uniform Rules on Agency Procedure subjects, so the Uniform Rules on Agency Procedure will apply to the Commission. However, under Iowa Code section 17A.24(3), an agency may adopt rules providing for additions, exceptions, or amendments to a uniform rule. Senate File 2463, section 5, authorizes emergency rulemaking for this purpose.

Under Senate File 2463, section 5, subsection 2, an agency may only adopt emergency rules upon making certain findings. The Commission finds that the emergency rules are otherwise necessary under Senate File 2463, section 5, subsection 2(b), as explained below.

Item 1 modifies a uniform rule by streamlining the requirements applicable to intervenors in declaratory order proceedings before the Commission. The uniform rule requires potential intervenors to detail facts supporting the intervenor's standing and qualifications for intervention. The Commission's

modification requires potential intervenors only to detail facts supporting the intervenor's qualifications for intervention. This modification is necessary because an intervenor's qualifications for intervention necessarily include the intervenor's standing, rendering a separate mention of standing superfluous.

Item 2 modifies a uniform rule by providing that lengthy and technical filings will not be required in certain categories of licensing appeals. The uniform rule provides that filing requirements in contested cases may be imposed by rule, by the notice of hearing, or by order of the presiding officer. The Commission's modification to this rule adds an exception clarifying that for certain categories of occupational licensing appeals, pleadings other than a notice of appeal will not be required. Adding this language to the rule is necessary because it avoids imposing a potential burden on occupational license applicants, many of whom are not represented by counsel when going through the licensing process.

#### *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.

#### *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 June 16, 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](mailto:barb.blake@iowa.gov)

#### *Public Hearing*

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

|               |                             |
|---------------|-----------------------------|
| June 16, 2026 | Commission Office           |
| 9 a.m.        | 6200 Park Avenue, Suite 100 |
|               | Des Moines, Iowa            |

Persons who wish to make oral comments at the 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 the 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).

*Emergency Rulemaking Adopted by Reference*

This proposed rulemaking is also published herein as an Adopted and Filed Emergency rulemaking (see **ARC 0296D**, IAB 5/27/26). The purpose of this Notice of Intended Action is to solicit public comment on that emergency rulemaking, whose subject matter is hereby adopted by reference.

**ARC 0306D****UTILITIES COMMISSION[199]****Notice of Intended Action****Proposing rulemaking related to service supplied by rate-regulated gas utilities and providing an opportunity for public comment**

The Utilities Commission hereby proposes to rescind Chapter 19, “Service Supplied by Rate-Regulated Gas Utilities,” Iowa Administrative Code, and to adopt a new Chapter 19 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Iowa Code chapter 476.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 476.

*Purpose and Summary*

Chapter 19 contains the Commission’s rules regulating services supplied by rate-regulated utilities in Iowa. The purpose of the rulemaking is largely to separate provisions related to municipal gas utilities to facilitate the creation of a new 199—Chapter 28. Existing Chapter 19 includes rules for both rate-regulated gas utilities and municipal gas utilities. The Commission has previously separated the rules for rate-regulated and municipal electric facilities, so this rulemaking continues that regulatory attempt to streamline rules for both utility types. These changes also allow the Commission to promote conformity between 199—Chapters 19, 27, and 28.

The Commission issued an order commencing rulemaking on April 16, 2026. The order is available on the Commission’s electronic filing system, [efs.iowa.gov](https://efs.iowa.gov), under Docket No. RMU-2025-0019.

*Regulatory Analysis*

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on January 7, 2026. A public hearing was held on the following date(s):

- February 12, 2026

The public hearing was attended by the Office of Consumer Advocate, a division of the Iowa Department of Justice; Iowa Association of Electric Cooperatives (IAEC); Black Hills/Iowa Gas Utility Company, LLC d/b/a Black Hills Energy (Black Hills); MidAmerican Energy Company (MidAmerican); and Interstate Power and Light Company. Based on the written and oral comments received, the Commission modified proposed Chapter 19 to produce the version in this Notice of Intended Action.

*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*

No waiver provision is included in the proposed amendments because the Commission has a general waiver provision in rule 199—1.3(17A,474,476) that provides procedures for requesting a waiver.

*Public Comment*

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on June 16, 2026. Comments should be directed to:

IT Support  
Iowa Utilities Commission  
Phone: 515.725.7300  
Email: [ITSupport@iuc.iowa.gov](mailto:ITSupport@iuc.iowa.gov)

*Public Hearing*

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

|                               |                                                                                        |
|-------------------------------|----------------------------------------------------------------------------------------|
| June 18, 2026<br>9 to 11 a.m. | Commission Hearing Room<br>1375 East Court Avenue<br>Des Moines, Iowa<br>Also via Zoom |
|-------------------------------|----------------------------------------------------------------------------------------|

Persons who wish to make oral comments at the 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 the 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 199—Chapter 19 and adopt the following **new** chapter in lieu thereof:

## CHAPTER 19

## SERVICE SUPPLIED BY RATE-REGULATED GAS UTILITIES

**199—19.1(476) General information.**

**19.1(1) Purpose and application of rules.** The rules shall apply to any rate-regulated gas utility operating within the state of Iowa as defined in Iowa Code chapter 476 and shall supersede any tariff on file with this commission that is in conflict with these rules. These rules are intended to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities.

**19.1(2) Definitions.** The following words and terms shall have the meaning indicated below:

“*Appliance*” means any device that utilizes gas fuel to produce light, heat, or power.

“*CFR*” means the Code of Federal Regulations in effect as of [the effective date of this chapter] unless a separate effective date is identified in a specific rule.

*“Complaint,”* as used in these rules, means a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility failure to fulfill an obligation.

*“Cubic foot”* of gas means:

1. Where gas is supplied and metered to customers at the pressure (as defined in subrule 19.7(2)) normally used for domestic customers’ appliances, a cubic foot of gas shall be that quantity of gas which, at the temperature and pressure existing in the meter, occupies one cubic foot, except that where a temperature compensated meter is used, the temperature base shall be 60°F.

2. When gas is supplied to customers at other than the pressure in “1” above, the utility shall specify in its rules the base for measurement of a cubic foot of gas (subparagraph 19.2(3) “c”(1)). Unless otherwise stated by the utility, such cubic foot of gas shall be that quantity of gas which, at a temperature of 60°F and a pressure of 14.73 pounds per square inch absolute, occupies one cubic foot.

3. The standard cubic foot of gas for testing the gas itself for heating value shall be that quantity of gas, saturated with water vapor, which, at a temperature of 60°F and a pressure of 30 inches of mercury, occupies one cubic foot. (Temperature of mercury = 32°F acceleration due to gravity = 32.17 ft. per second per second density = 13.595 grams per cubic centimeter.)

*“Customer”* means any person, firm, association, or corporation; any agency of the federal, state or local government; or any legal entity responsible by law for payment for the gas service or heat from the gas utility, including a guarantor of service for another customer.

*“Delinquent”* or *“delinquency”* means an account for which a service bill or service payment agreement has not been paid in full on or before the last day for timely payment.

*“Gas,”* unless otherwise specifically designated, means manufactured gas, natural gas, other hydrocarbon gases, or any mixture of gases produced, transmitted, distributed or furnished by any gas utility.

*“Gas plant”* means all facilities including all real estate, fixtures and property owned, controlled, operated or managed by a gas utility for the production, storage, transmission or distribution of gas and heat.

*“Interruption of service”* means any disturbance of the gas supply whereby gas service to a customer cannot be maintained.

*“Main”* means a gas pipe, excluding a service line, that is owned, operated, or maintained by a utility and is used for the purpose of distribution of gas.

*“Master meter”* means a single meter used in determining the amount of gas provided to a multitenant building or to multiple buildings.

*“Meter,”* without other qualification, means any device or instrument used by a utility in measuring a quantity of gas.

*“Meter shop”* means a shop where meters are inspected, repaired and tested, and may be at a fixed location or may be mobile.

*“Plant addition”* means any additional plant, other than a distribution main or service line, required to be constructed to provide service to a customer.

*“Pressure,”* unless otherwise stated, is expressed in pounds per square inch above atmospheric pressure, i.e., gauge pressure (abbreviation: psig).

*“Rate-regulated utility”* means any utility that is subject to rate regulation as provided in Iowa Code chapter 476.

*“Rates”* means the per-unit or per-occurrence amounts billed to customers for a recurring or nonrecurring service or commodity rendered or offered by the utility and any charge, schedule, or regulation that a utility includes in a tariff approved by the commission.

*“Service line”* means a distribution gas pipe that transports gas from a main or source of supply to a customer meter or the connection to a customer’s piping, whichever is farther downstream, or the connection to a customer’s piping if there is not a customer meter. A customer meter is the meter that measures the transfer of gas from a utility to a customer.

*“Tap”* or *“town border station”* means the delivery point or measuring station at which a gas utility receives gas from a natural gas transmission company.

“*Tariff*” means the entire body of rates, tolls, rentals, charges, classifications, rules, procedures, policies, etc., adopted and filed with the commission by a gas utility in fulfilling its role of furnishing gas service.

“*Therm*” means 100,000 British thermal units.

“*Timely payment*” means a payment on a customer’s account made on or before the date shown on a current bill for service or on a form that records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date that determines application of a late payment charge.

“*Utility*” means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any gas plant for furnishing gas or heat to the public for compensation, and is a rate-regulated utility subject to this chapter.

**19.1(3) Abbreviations.** The abbreviations used, and their meanings, are as follows:

“*Btu*”—British thermal unit

“*LP gas*”—liquefied petroleum gas

### **199—19.2(476) Records, reports, and tariffs.**

**19.2(1) Tariffs to be filed with the commission.** The schedules of rates and rules of gas utilities shall be filed with the commission in accordance with this chapter. Tariff provisions will be definite and clear.

**19.2(2) Form and identification.** All tariffs shall conform to the following rules:

- a. The tariff shall conform to the following requirements:
  - (1) Be on 8½ by 11-inch pages so as to result in a clear and permanent record.
  - (2) Be filed electronically in compliance with 199—Chapter 14.
  - (3) The first page is the title page, which will show the name of the utility, the type of utility service being provided, the words “Filed with Iowa Utilities Commission” and the date.
  - (4) When a tariff is to be superseded or replaced in its entirety, the replacing tariff will show on the upper right corner of its title page that it is a revision of a tariff on file and the number being superseded or replaced.
  - (5) When a tariff sheet in a tariff is revised, amended, or eliminated, the tariff sheet will indicate in the upper right corner the number of the revision to that tariff sheet.
  - (6) Any tariff sheet modifications will be marked in the right margin with symbols as described below to indicate the place, nature, and extent of the change in text. The marked version will show all added language marked with underlined text and all deleted language with strike-through.
    1. (C)—Change in regulation.
    2. (D)—Discontinued rate or regulation.
    3. (I)—Increase in rate or new treatment resulting in increased rate.
    4. (L)—Changed text location.
    5. (N)—New rate, treatment, or regulation.
    6. (R)—Reduction in rate or new treatment resulting in reduction in rate.
    7. (T)—Change in text only.
  - (7) All sheets except the title page will have the following information located at the upper left corner of the tariff sheet:
    1. Company name.
    2. Type of utility tariff.
    3. The words “Filed with commission.”
  - (8) All sheets except the title page will have the following information located at the upper right corner of the tariff sheet:
    1. Tariff part identification, if any.
    2. Tariff sheet number, original or revised.
    3. Canceled tariff sheet number, original or revised.
  - (9) All sheets except the title page will have the following information located at the lower left corner of the tariff sheet:
    1. The issued date.

2. The name of the person responsible for the issuance.

(10) All sheets except the title page will have the following information located at the lower right corner of the tariff sheet:

1. An effective date field.

2. Proposed effective date.

b. The issued date is the date the tariff or the revised sheet content was filed by the utility in the commission's electronic filing system.

c. The effective date is to be left blank by the utility and will be determined by the commission.

**19.2(3)** *Content of tariffs.* A tariff filed with the commission shall contain:

a. A table of contents containing a list of rate schedules and other sections in the order in which they appear that indicates the first page of each section.

b. All rates for each type of gas as they apply to each class of customer. Tariffs will also include the prices per unit of service, the number of units per billing period to which the prices apply, the period of billing, the minimum bill, the method of measuring demands and consumptions, including the method of calculating or estimating loads or minimums, delivery pressure, and any special terms or conditions applicable. All rates, books, and records should be separated into "gas" and "nongas" components. Books and records shall be available to the commission for audits upon request. The gas components will be the result of the utility's periodic review of gas procurement practices (rule 199—19.10(476)) and PGA (rule 199—19.9(476)) proceeding. The nongas components will be established through rate case proceedings under Iowa Code section 476.3 or 476.6. The period during which the net amount may be paid before the account becomes delinquent shall be specified. In any case where net and gross amounts are billed, the difference between net and gross is a late payment charge and shall be so specified.

Customer charges for all special services relating to providing the basic utility service, including disconnection, reconnection, and service or trip charges, shall be specified.

c. A copy of the utility's rules, or terms and conditions, describing the utility's policies and practices in providing service shall include:

(1) A statement as to the equivalent total heating value of the gas in Btus per cubic foot on which the customers are billed. If necessary, this may be listed by district, division or community.

(2) A list of the items that the utility furnishes, owns, and maintains on the customer's premises, such as service pipe, meters, regulators, vents, and shut-off valves.

(3) A general statement indicating the extent to which the utility will provide service in the adjustment of customer appliances at no additional customer charge.

(4) A general statement of the utility's policy in making adjustments for wastage of gas when such wastage occurs without the knowledge of the customer.

(5) A statement indicating the minimum number of days allowed for payment after the due date of the customer's bill before service will be discontinued for nonpayment.

(6) A statement indicating the volumetric measurement base to which all sales of gas at other than standard delivery pressure are corrected.

(7) Forms of standard contracts required of customers for the various types of service available.

(8) A statement indicating that all rates and charges contained in this tariff or contract with reference thereto may be modified at any time by a subsequent filing made pursuant to the provisions of Iowa Code chapter 476.

(9) A copy of each type of customer bill.

(10) Definitions of classes of customers.

(11) Rules for extending service in accordance with subrule 19.3(7).

(12) Rules with which prospective customers must comply as a condition of receiving service, and the terms of contracts required.

(13) Rules governing the establishment and maintenance of credit by customers for payment of service bills.

(14) Rules governing disconnecting and reconnecting service.

(15) Notice required from customer for having service discontinued.

- (16) Rules covering temporary, emergency, auxiliary, and stand-by service.
- (17) Rules that address any limitations on loads or the type of equipment that may or may not be connected.
- (18) A list of service areas and the applicable rates in such form as to facilitate ready determination of the rates available in each municipality and in such unincorporated communities as have service.
- (19) Rules on meter reading, billing periods, bill issuance, timely customer payment, notice of delinquency and service disconnection for nonpayment of bill.
- (20) Rules on how a customer or prospective customer should file a complaint with the utility, and how the complaint will be processed.
- (21) Rules on how a customer, disconnected customer or potential customer for residential service may negotiate for a payment agreement on amount due, determination of even payment amounts, and time allowed for payments.
- (22) If a sliding scale or automatic adjustment is applicable to regulated rates or charges of billed customers, the manner and method of such adjustment calculation through a detailed explanation.

**19.2(4)** *Annual, periodic and other reports to be filed with the commission.*

*a. System map verification.* A utility shall file annually with the commission a verification that it has a correct set of utility system maps for each operating or distribution area. The maps are to be available to commission personnel upon request. The maps shall show:

- (1) Peak shaving facility location(s).
- (2) Feeder and distribution mains indicating size and pressure.
- (3) System metering (town border stations and other supply points).
- (4) Regulator stations in system indicating inlet and outlet pressures.
- (5) Calorimeter location.
- (6) State boundary crossing.
- (7) Franchise area.
- (8) Names of all communities (post offices) served.

*b. Reports of gas service.* Each utility shall compile a monthly record of gas service, which will be available to the commission upon request. The record shall be completed within 30 days after the end of the month covered. Such record shall contain:

- (1) The daily and monthly average of total heating values of gas in accordance with subrule 19.7(6).
- (2) The monthly acquisition and disposition of gas.
- (3) Interruptions of service occurring during the month in accordance with subrule 19.7(7). If there were no interruptions, then it should be so stated.
- (4) The number of customer pressure investigations made and the results.
- (5) The number of customer meters tested and test results tabulated as follows: The number that falls into limits 0 to + 2%, + 2 to + 4%, 0 to - 2%, - 2 to - 4%, over + 4%, under - 4%, and "Does Not Register" in accuracy.
- (6) Progress on leak survey programs including the number of leaks found classified as to hazard and nature, and if known, the cause and type of pipe involved.
- (7) Number of district regulators checked and nature of repairs required.
- (8) Number of house regulators checked and nature of repairs required.
- (9) Description of any unusual operating difficulties.
- (10) Type of odorant and monthly average pounds per million cubic feet used in each individual distribution system.

*c. Filing published meter and service installation rules.* A copy of the utility's current rules, if any, published or furnished by the utility for use by engineers, architects, plumbing contractors, etc., covering meter and service installation shall be filed with the commission.

*d. Filing customer bill forms.* A copy of each type of customer bill form in current use shall be filed with the commission.

*e. Reports to federal agencies.* Copies of reports submitted to the U.S. Department of Transportation pursuant to 49 CFR Part 191, 192, 193, or 199 shall be filed with the commission no



later than ten days following the submission. Utilities operating in other states shall provide data to the commission for Iowa only.

*f. Change in rate.* A notification to the commission shall be made of any planned change in rate of service by a utility. This information shall reflect the amount of increase or decrease and the effective date of application. An up-to-date tariff sheet shall be supplied to the commission showing the current rates.

*g. Residential customer statistics.* Each utility shall file with the commission on or before the fifteenth day of each month one copy of the following residential customer statistics for the preceding month:

- (1) Number of accounts;
- (2) Number of accounts certified as eligible for energy assistance since the preceding October 1;
- (3) Number of accounts past due;
- (4) Number of accounts eligible for energy assistance and past due;
- (5) Total revenue owed on accounts past due;
- (6) Total revenue owed on accounts eligible for energy assistance and past due;
- (7) Number of disconnection notices issued;
- (8) Number of disconnection notices issued on accounts eligible for energy assistance;
- (9) Number of disconnections for nonpayment;
- (10) Number of reconnections;
- (11) Number of accounts deemed uncollectible; and
- (12) Number of accounts eligible for energy assistance and deemed uncollectible.

*h. Monthly, periodic and annual reports.* Each utility shall file such other monthly, periodic and annual reports as are requested by the commission. Monthly and periodic reports shall be due in the commission's office within 30 days after the end of the reporting period. All annual reports shall be filed with the commission by April 1 of each year for the preceding calendar year.

This rule is intended to implement Iowa Code section 476.2.

### **199—19.3(476) General service requirements.**

**19.3(1) Disposition of gas.** The meter and any service line pressure regulator shall be owned by the utility. The utility shall place a visible seal on all meters and service line regulators in customer use, such that the seal must be broken to gain entry.

*a.* All gas sold by a utility shall be on the basis of meter measurement except:

- (1) Where the consumption of gas may be readily computed without metering; or
- (2) For temporary service installations.

*b.* The amount of all gas delivered to multitenant buildings shall be measured on the basis of individual meter measurement for each unit, except in the following instances:

- (1) Where gas sold by a utility is used as the primary energy source in centralized heating, cooling, or water-heating systems;
- (2) Where a facility is designated for elderly or handicapped persons;
- (3) Where submetering or resale of service was permitted prior to 1966; or
- (4) Where individual metering is impractical. "Impractical" means:
  1. Where conditions or structural barriers exist that would make individual meters unsafe or physically impossible to install; or
  2. Where the cost of providing individual metering exceeds the long-term benefits of individual metering.

(5) Where the benefits of individual metering (reduced or controlled energy consumption) are more effectively accomplished through a master meter arrangement.

1. A new multitenant building qualifies for master metering under this subparagraph if the predicted annual gas use would result in at least a 30 percent savings compared to the predicted annual gas use of a new building meeting the requirements of the state of Iowa energy code and operating with equipment, fixtures, and appliances meeting federal gas standards for manufactured devices for a new building.

2. An existing multitenant building qualifies for master metering under this subparagraph when the predicted annual gas use would result in at least a 20 percent gas savings compared to the building's current annual gas usage levels.

3. In determining whether a building's predicted annual gas use would result in at least a 20 or 30 percent savings, all relevant factors that decrease the building's gas usage may be considered, so long as each factor is relevant to why master metering more effectively reduces or controls the building's gas consumption. This includes but is not limited to new or more efficient equipment, materials, or appliances; improved operating practices; changes in fuel type; or structural improvements. This does not affect the determination made for buildings approved prior to July 16, 2025.

4. A report from a qualified independent third party stating that the proposed building or renovation will meet the gas savings requirements of this subparagraph shall establish a rebuttable presumption of eligibility for master metering. "Qualified, independent third party" means a licensed architect or engineer, a certified residential energy services network home energy rating system (RESNET HERS) rater, or any other professional deemed qualified by the commission.

c. If a multitenant building is master metered, the end user occupants may be charged for natural gas as an unidentified portion of the rent, condominium fee, or similar payment, or, if some other method of allocating the cost of the gas service is used, the total charge for gas service shall not exceed the total gas bill charged by the utility for the same period.

d. Master metering to multiple buildings is prohibited, except for multiple buildings owned by the same person or entity. Multitenant premises within a multiple building complex may be master-metered pursuant to this paragraph only if the requirements of paragraph 19.3(1) "b" have been met.

e. All gas consumed by the utility shall be on the basis of meter measurement except where consumption may be readily computed without metering or where metering is impractical.

**19.3(2) *Meter reading records.*** The meter reading records shall show:

- a. Customer's name, address, rate schedule, or identification of rate schedule.
- b. Identifying number or description of the meter(s).
- c. Meter readings.
- d. Whether the reading has been estimated.
- e. Any applicable multiplier or constant.

**19.3(3) *Meter register.*** If it is necessary to apply a multiplier to the meter readings, the multiplier must be marked on the face of the meter register or stenciled in weather-resistant paint upon the front cover of the meter. Customers shall have continuous visual access to meter registers as a means of verifying the accuracy of bills presented to them and for implementing energy conservation initiatives as they desire. Where remote meter reading is used, whether outdoor on premises or off-premises-automated, the customers shall have a readable meter register at the meter as a means of verifying the accuracy of bills presented to them. A utility may comply with the requirements of this subrule by making the required information available via the internet or other equivalent means.

**19.3(4) *Prepayment meters.*** Prepayment meters shall not be geared or set so as to result in the charge of a rate or amount higher than would be paid if a standard type meter were used, except under tariffs approved by the commission.

**19.3(5) *Meter reading and billing interval.***

a. Readings of all meters used for determining charges and billings to customers shall be scheduled at least monthly and for the beginning and termination of service. Bills to larger customers may, for good cause, be provided weekly or daily for a period not to exceed one month. Intervals other than monthly shall not be applied to smaller customers, or to larger customers after the initial month provided above, without a waiver from the commission. If the commission denies a waiver, or if a waiver is not sought with respect to a large-volume customer after the initial month, that customer's bill shall be provided monthly for the next 12 months. The group of larger customers to which shorter billing intervals may be applied shall be specified in the utility's tariff sheets, but shall not include residential customers.

b. Utilities should obtain readings of the meters on corresponding days of each meter reading period when possible. Unless the utility has a plan to test check meter readings, a utility representative

shall physically read the meter at least once each 12 months and when the utility is notified there is a change of customer.

**19.3(6) *Readings and estimates.***

a. When a customer is connected or disconnected or the meter reading date causes a given billing period to deviate by more than 10 percent (counting only business days) from the normal meter reading period, such bill shall be prorated on a daily basis.

b. When access to a meter cannot be gained, the utility may, at its discretion, leave with the customer a meter reading form. The customer may provide the meter reading by telephone, email (if it is allowed by the utility), or mail. If the meter reading information is not obtained in time for the billing operation, an estimated bill may be provided. If an actual meter reading cannot be obtained, the utility may provide an estimated bill without reading the meter or supplying a meter reading form to the customer. Only in unusual cases or when approval is obtained from the customer shall more than three consecutive estimated bills be provided.

c. Utilities will file with the commission procedures for calculating bill estimates, which incorporate normalized weather data, as well as procedures for determining the reasonable heating degree day data to use in the calculations. Utilities shall inform the commission when changes are made to the procedures for calculating estimated bills.

**19.3(7) *Plant additions, distribution main extensions, and service lines.***

a. *Definitions.* The following definitions apply to the terms in this subrule:

*“Advance for construction”* means cash payments or equivalent surety made to the utility by an applicant for an extensive plant addition or a distribution main extension, portions of which may be refunded depending on any subsequent service line attached to the extensive plant addition or distribution main extension. Cash payments or equivalent surety shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

*“Agreed-upon attachment period”* means a period of no less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

*“Contribution in aid of construction”* means a nonrefundable cash payment grossed-up for the income tax effect of such revenue covering the costs of a service line that are in excess of costs paid by the utility. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

*“Distribution main extension”* means a segment of pipeline installed to convey gas to individual service lines or other distribution mains.

*“Estimated base revenues”* means an amount calculated by subtracting the cost of purchased gas and energy efficiency charges from estimated annual revenues.

*“Estimated construction costs”* means an amount calculated using average current costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the distribution main extension or service line; size, location, and characteristics of the distribution main extension or service line, including appurtenances; and whether the ground is frozen or whether other adverse conditions exist. Estimated construction costs shall not include costs associated with facilities built for the convenience of the utility. The customer shall be charged actual permit fees in addition to estimated construction costs. Permit fees are to be paid regardless of whether the customer is required to pay an advance for construction or a nonrefundable contribution in aid of construction, and the cost of any permit fee is not refundable.

*“Similarly situated customer”* means a customer whose annual consumption or service requirements, as defined by estimated annual revenue, are approximately the same as the annual consumption or service requirements of other customers.

b. *Plant additions.* The utility shall provide all gas plant at its cost and expense without requiring an advance for construction from customers or developers, except in those unusual circumstances where extensive plant additions are required before the customer can be served. A written contract between

the utility and the customer that requires an advance for construction by the customer to make plant additions shall be available for commission inspection.

*c. Distribution main extensions.* Where the customer will attach to the distribution main extension within the agreed-upon attachment period after completion of the distribution main extension, the following shall apply:

(1) The utility shall finance and make the distribution main extension for a customer without requiring an advance for construction if the estimated construction costs to provide a distribution main extension are less than or equal to six times estimated base revenue calculated on the basis of similarly situated customers. If the utility uses a feasibility model to determine an advance for construction, the utility will file a summary explaining the model's inputs and a description of the model as part of the utility's tariff. The utility may charge customers for actual permit fees and additional costs associated with construction during adverse conditions, which are not refundable.

(2) If the estimated construction cost to provide a distribution main extension is greater than six times estimated base revenue calculated on the basis of similarly situated customers, the applicant for a distribution main extension shall contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction based upon the following formula:

(estimated construction cost – 6 x estimated base revenues)

If a utility uses a feasibility model to determine if an advance for construction is necessary, it will file a summary explaining the model's inputs and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for commission inspection upon request. The utility will provide the customer with a cost estimate that details the costs and credits, by category. The utility may charge customers for actual permit fees, which are not refundable.

(3) Where the customer will not attach within the agreed-upon attachment period after completion of the distribution main extension, the applicant for the distribution main extension shall contract with the utility and make, no more than 30 days prior to the commencement of construction, an advance for construction equal to the estimated construction cost. The utility may use a feasibility model to determine the amount of the advance for construction. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for commission inspection upon request. Whether or not the construction of the distribution main extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees and additional costs associated with construction during adverse conditions, and the permit fees are not refundable.

(4) Advances for construction may be paid by cash or equivalent surety, unless the customer has failed to comply with the conditions of surety in the past, and shall be refundable for ten years.

(5) When the customer is required to make an advance for construction, the utility shall refund the advance in aid of construction to the depositor for a period of ten years from the date of the original advance a pro rata share for each service line attached to the distribution main extension no less than four times per year.

1. The utility will provide the customer receiving the refund with a statement detailing the refund calculation.

2. Any amounts subject to refund shall be paid by the utility without interest.

(6) The utility shall keep a record of each work order under which the distribution main extension was installed, to include the estimated revenues, the estimated construction costs, the amount of any payment received, and any refunds paid.

*d. Service lines.*

(1) The utility shall finance and construct a service line without requiring a contribution in aid of construction or any payment by the applicant where the length of the service line to the riser is up to 50 feet on private property or 100 feet on private property if polyethylene plastic pipe is used.

(2) Where the length of the service line exceeds 50 feet on private property or 100 feet if polyethylene plastic pipe is used, the applicant shall provide a nonrefundable contribution in aid of construction for that portion of the service line on private property in excess of 50 feet or in excess of

100 feet if polyethylene plastic pipe is used, exclusive of the riser, within 30 days after completion. The contribution in aid of construction for that portion of the service line shall be computed as follows:

(Estimated Construction Costs) ×

$$\frac{(\text{Total Length in Excess of 50 Feet}) \text{ or } (\text{Total Length in Excess of 100 Feet})}{(\text{Total Length of Service Line})}$$

(3) A utility may adopt a tariff or rule that allows the utility to finance and construct a service line of more than 50 feet, or 100 feet if polyethylene plastic pipe is used, without requiring a contribution in aid of construction from the customer if the tariff or rule applies equally to all customers.

(4) Whether or not the construction of the service line would otherwise require a payment from the customer, the utility may charge the customer for actual permit fees and additional costs associated with construction during adverse conditions.

*e. Extensions.* Utilities are not required to make distribution main extensions or attach service lines as described in this subrule unless the distribution main extension or service line shall be of a permanent nature. When the utility provides a temporary service to a customer, the utility may require that the customer bear all of the cost of installing and removing the service in excess of any salvage realized.

*f. Different payment arrangement.* Utilities may make a contract with a customer using a different payment arrangement than provided in this subrule, if the contract provides a more favorable payment arrangement to the customer, so long as no discrimination is practiced among similarly situated customers.

*g. Areas without service or with constrained service.*

(1) A utility may finance and expand natural gas service into an area of the state with no natural gas service or where capacity constraints limit the expansion of service. A utility expanding service under this paragraph may do so without requiring an advance for construction from a customer or group of customers if a standard feasibility model approved by the commission shows the expansion is economically justified over a period not to exceed 20 years. The approved model will be adopted following a commission proceeding in which interested parties will have the opportunity to review and comment on a model jointly proposed by the regulated gas utilities. The approved model will be made available on the commission's website. The utility shall charge the customer or customers for actual permit fees, and the permit fees are not refundable.

(2) If the feasibility model does not show the expansion is economically justified without an advance for construction, a customer or group of customers may contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction in an amount that would make the expansion economically justified.

(3) Upon making a determination that it intends to move forward with an expansion pursuant to this paragraph, the utility shall notify the commission by filing the inputs and results of the feasibility model and any associated contract or contracts with the commission. The utility shall maintain separate books and records for any expansion made pursuant to this paragraph until the utility's next general rate case proceeding.

**19.3(8) Cooperation and advance notice.** In order that full benefit may be derived from this chapter and in order to facilitate its proper application, all utilities shall observe the following cooperative practices:

*a.* A utility will provide all other public utilities in the same general territory advance notice of any construction or change in construction or in operating conditions of its facilities concerned or likely to be concerned in situations of proximity.

*b.* All utilities will assist in promoting conformity with this chapter. An arrangement should be set up among all utilities whose facilities may occupy the same general territory, providing for the interchange of pertinent data and information including that relative to proposed and existing construction and changes in operating conditions concerned or likely to be concerned in situations of proximity.

This rule is intended to implement Iowa Code section 476.3.

**199—19.4(476) Customer relations.****19.4(1) Customer information.** Each utility shall:

- a. Maintain up-to-date maps, plans or records of its entire transmission and distribution systems, with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving customers in its service area.
- b. Assist customers or prospective customers in selecting the most economical rate schedule available for the proposed type of service.
- c. Notify customers affected by a change in rates or schedule classification in the manner provided in the rules of practice and procedure before the commission (rule 199—26.4(476A)).
- d. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility, as filed with the commission, are available for public inspection. If the utility provides access to its rate schedules and rules for service on its website, the notice shall include the website address.
- e. Upon request, inform its customers as to the method of reading meters.
- f. State, on the bill form, that tariff and rate schedule information is available upon request at the utility's local business office. If the utility provides access to its tariff and rate schedules on its website, the statement shall include the website address.
- g. Upon request, transmit a statement of either the customer's actual consumption, or degree day adjusted consumption, at the company's option, of natural gas for each billing period during the prior 12 months.
- h. Furnish such additional information as the customer may reasonably request.

**19.4(2) Customer contact employee qualifications.** Utilities will promptly and courteously resolve inquiries for information or complaints. Employees who receive customer telephone calls, emails, and office visits shall be qualified and trained in screening and resolving complaints to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer that will enable the customer to reach that employee again if needed.

Each utility will notify their customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Commission by calling 515.725.7300 or toll-free 877.565.4450, or by writing to 1375 E. Court Ave., Des Moines, IA 50319-0069, or by email to [customer@iuc.iowa.gov](mailto:customer@iuc.iowa.gov)."

The bill insert or notice on the bill form shall be provided monthly. Any utility that does not use the standard statement described in this subrule will file its proposed statement in its tariff for approval.

**19.4(3) Customer deposits.**

- a. Each utility may require from any customer or prospective customer a deposit intended to guarantee partial payment of bills for service. Each utility will allow a person other than the customer to pay the customer's deposit. In lieu of a cash deposit, the utility may accept the written guarantee of a surety or other responsible party as surety for an account. Upon termination of a guarantee contract, or whenever the utility deems the contract insufficient as to amount or surety, a cash deposit or a new or additional guarantee may be required for good cause upon reasonable written notice.
- b. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer will have no less than 12 days from the date of mailing to comply. The new or additional deposit shall be payable at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. The utility does not need to provide written notice of a deposit required as a prerequisite for commencing initial service.
- c. No deposit shall be required as a condition for service other than determined by application of either credit rating or deposit calculation criteria, or both, of the filed tariff.

d. The total deposit for any residential or commercial customer for a place that has previously received service shall not be greater than the highest billing of service for one month for the place in the previous 12-month period. The deposit for any residential or commercial customer for a place that has not previously received service or for an industrial customer shall be the customer's projected one-month usage for the place to be served as determined by the utility or as may be reasonably required by the utility in cases involving service for short periods or special occasions.

**19.4(4) *Interest on customer deposits.*** Interest will be paid by each utility to each customer required to make a deposit. Utilities will compute interest on customer deposits at 7.5 percent per annum, compounded annually. Interest is to be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

**19.4(5) *Customer deposit records.*** Each utility shall keep records to show:

- a. The name and address of each depositor.
- b. The amount and date of the deposit.
- c. Each transaction concerning the deposit.

**19.4(6) *Customer's receipt for a deposit.*** Utilities will issue a receipt of deposit to each customer from whom a deposit is received and provide means whereby a depositor may establish claim if the receipt is lost.

**19.4(7) *Deposit refund.*** A deposit shall be refunded after 12 consecutive months of prompt payment (which may be 11 timely payments and one automatic forgiveness of late payment) unless the utility is entitled to require a new or additional deposit. For refund purposes, accounts will be reviewed after 12 months of service following the making of the deposit and for each 12-month interval terminating on the anniversary of the deposit. However, deposits received from customers subject to the waiver provided by subrule 19.3(5), including surety deposits, may be retained by the utility until final billing. Upon termination of service, the deposit plus accumulated interest, less any unpaid utility bill of the customer, shall be reimbursed to the person who made the deposit.

**19.4(8) *Unclaimed deposits.*** Utilities will make reasonable efforts to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, will be sent to the state treasurer pursuant to Iowa Code section 556.11.

**19.4(9) *Customer bill forms.*** Each customer shall be informed as promptly as possible following the reading of the customer's meter, on bill form or otherwise, of the following:

- a. The reading of the meter at the beginning and at the end of the period for which the bill is provided.
- b. The dates on which the meter was read at the beginning and end of the billing period.
- c. The number and kind of units metered.
- d. The applicable rate schedule with the identification of the applicable rate classification.
- e. The account balance brought forward and the amount of each net charge for rate-schedule-priced utility service, sales tax, other taxes, late payment charge, and total amount currently due. In the case of prepayment meters, the amount of money collected shall be shown.
- f. The last date for timely payment, which will not be less than 20 days after the bill is provided.
- g. A distinct marking to identify an estimated bill, when applicable.
- h. A distinct marking to identify a minimum bill.
- i. Any conversions from meter reading units to billing units, or any calculations to determine billing units from recording or other devices, or any other factors, such as sliding scale or automatic adjustment and amount of sales tax adjustments used in determining the bill.

**19.4(10) *Payment agreements.***

*a. Availability of a first payment agreement.* When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to a utility for residential utility service and is not in default of a payment agreement with the utility, the utility shall offer the customer an opportunity to enter into a reasonable payment agreement. The offer of a payment agreement is to be made prior to disconnection.

*b. Reasonableness.* Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of health and human services or another agency.

*c. Terms of payment agreements.*

(1) First payment agreement. The utility shall offer the following conditions to customers who have received a disconnection notice or who have been previously disconnected and are not in default of a payment agreement:

1. For customers who received a disconnection notice or who have been disconnected less than 120 days and are not in default of a payment agreement, the utility shall offer an agreement with at least 12 even monthly payments. For customers who have been disconnected more than 120 days and are not in default of a payment agreement, the utility shall offer an agreement with at least six even monthly payments. Utilities will inform customers they may pay off the delinquency early without incurring any prepayment penalties.

2. The agreement shall also include provision for payment of the current account.

3. The utility may also require the customer to enter into a budget billing plan to pay the current bill.

4. When the customer makes the agreement in person, a signed copy of the agreement shall be provided to the customer.

5. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission.

6. When the customer makes the agreement over the telephone or through electronic transmission, the utility shall provide to the customer a written document reflecting the terms and conditions of the agreement within three days of the date the parties entered into the oral agreement or electronic agreement.

7. The document will be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the document is considered provided to the customer when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing.

8. The document shall state that unless the customer notifies the utility otherwise within ten days from the date the document is provided, it will be deemed that the customer accepts the terms as reflected in the written document. The document stating the terms and agreements shall include the address and a toll-free or collect telephone number where a qualified representative can be reached.

9. Once the first payment required by the agreement is made by the customer or on behalf of the customer, the oral or electronic agreement is deemed accepted by the customer.

10. Each customer entering into a first payment agreement shall be granted at least one late payment that is four days or less beyond the due date for payment, and the first payment agreement shall remain in effect.

11. The initial payment is due on the due date for the next regular bill.

12. A customer shall not be charged interest, or a late payment charge, on a payment agreement where the customer is making payments consistent with the terms of the payment agreement.

(2) Second payment agreement. The utility shall offer a second payment agreement to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement.



1. The second payment agreement shall be for a term at least as long as the term of the first payment agreement.

2. The customer shall pay for current service in addition to the monthly payments under the second payment agreement and may be required to make the first payment up-front as a condition of entering into the second payment agreement.

3. The utility may also require the customer to enter into a budget billing plan to pay the current bill.

(3) Additional payment agreements. The utility may offer additional payment agreements to the customer.

*d. Refusal by utility.*

(1) A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally, but the utility must provide a written refusal of the customer's final offer, stating the reason for the refusal, within three days of the oral notification. The written refusal shall be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal shall be considered provided to the customer when handed to the customer, delivered to the last-known address of the customer, or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing.

(2) A customer may ask the commission for assistance in working out a reasonable payment agreement within ten days after the written refusal is provided. During the review of this request, the utility shall not disconnect the service.

**19.4(11) Bill payment terms.** The bill is considered provided to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill is considered provided when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing. An account shall not be delinquent until 20 days have passed since the bill was provided to the customer. For customers on more frequent billing intervals, an account shall not be delinquent until five days have passed since the bill was provided to the customer. A late payment charge will not be assessed if payment is received within 20 days of the date the bill is provided.

*a.* The date of delinquency for all residential customers or other customers whose consumption is less than 250 ccf per month shall be changeable for cause, such as but not limited to 15 days from the approximate date each month upon which income is received by the person responsible for payment. Utilities are not required to delay the date of delinquency more than 30 days beyond the date of preparation of the previous bill.

*b.* In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge shall not exceed 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge. This rule does not prohibit cost-justified charges for disconnection and reconnection of service.

*c.* If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall be credited pro rata between the bill for utility services and related taxes.

*d.* Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified that the eligibility has been used. Complete forgiveness means no effect upon the credit rating of the customer and no collection of late payment charge.

*e.* Budget billing plan. Utilities shall offer a budget billing plan to all residential customers or other customers whose consumption is less than 250 ccf per month. A budget billing plan should be designed

to limit the volatility of a customer's bill and maintain reasonable account balances and will include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service. The plan may be estimated if there is insufficient usage history to create a budget billing plan based on actual use.

(2) Allow for entry into the budget billing plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer may obtain a refund or apply the credit to future charges. A utility is not required to offer a new budget billing plan to a customer for six months after the customer has terminated from a budget billing plan.

(4) Use a computation method that produces a reasonable monthly budget billing amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in this subrule. The computation method used by the utility shall be described in the utility's tariff. The utility shall give notice to customers when it changes the type of computation method in the budget billing plan.

1. The amount to be paid at each billing interval by a customer on a budget billing plan shall be computed at the time of entry into the plan and be recomputed at least annually. The budget billing amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

2. When the budget billing amount is recomputed, the utility shall divide the budget billing plan account balance by 12, and add the resulting amount to the estimated monthly budget billing amount. Except when a utility has a budget billing plan that recomputes the budget billing amount monthly, the customer may apply any credit to payments of subsequent months' budget billing amounts due or obtain a refund of any credit in excess of \$25.

3. Except when a utility has a budget billing plan that recomputes the budget billing amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing cycle prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

4. Irrespective of the account balance, a delinquency in payment is subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the budget billing amount. If the account balance is a credit, the budget billing plan may be terminated by the utility after 30 days of delinquency.

**19.4(12) *Customer records.*** The utility shall retain customer billing records for the length of time necessary to permit the utility to comply with subrule 19.4(13) but not less than five years. Customer billing records shall show, where applicable:

- a. Therm consumption.
- b. Meter reading.
- c. Total amount of bill.

**19.4(13) *Adjustment of bills.*** Bills that are incorrect due to billing errors or faulty metering installation are to be adjusted as follows:

a. Fast metering. Whenever a metering installation is tested and found to have overregistered more than 2 percent, the utility shall recalculate the bills for service.

(1) The bills for service shall be recalculated from the time at which the error first developed or occurred if that time can be definitely determined.

(2) If the time at which the error first developed or occurred cannot be definitely determined, it shall be assumed that the overregistration has existed for the shortest time period calculated as one-half the time since the meter was installed or one-half the time elapsed since the last meter test unless otherwise ordered by the commission.

(3) If the recalculated bills indicate that \$5 or more is due an existing customer or \$10 or more is due a person no longer a customer of the utility, the tariff shall provide for refunding of the full amount of the calculated difference between the amount paid and the recalculated amount. Refunds shall be

made to the two most recent customers who received service through the metering installation during the time the error existed. In the case of a previous customer who is no longer a customer of the utility, a notice of the amount subject to refund shall be mailed to such previous customer at the last-known address, and the utility shall, upon demand made within three months thereafter, refund the same.

Refunds shall be completed within six months following the date of the metering installation test.

b. Slow metering. Whenever a meter is found to be more than 2 percent slow, the tariff may provide for back billing the customer for the amount the test indicates has been undercharged for the period of inaccuracy.

When the average error cannot be determined by test because of failure of part or all of the metering equipment, the tariff may provide for use of the registration of check metering installation, if any, or for estimating the quantity consumed based on available data. The utility will advise the customer of the failure and of the basis for the estimate of quantity billed.

(1) The utility may not back bill due to underregistration unless a minimum back bill amount is specified in its tariff. The minimum amount specified for back billing shall not be less than \$5 for an existing customer or \$10 for a former customer. All recalculations resulting in an amount due equal to or greater than the tariff specified minimum shall result in issuance of a back bill.

(2) The period for back billing shall not exceed the last six months the meter was in service unless otherwise ordered by the commission.

(3) Back billings shall be provided no later than six months following the date of the metering installation test.

c. Billing adjustments due to fast or slow meters shall be calculated on the basis that the meter should be 100 percent accurate. For the purpose of billing adjustment, the meter error shall be one-half of the algebraic sum of the error at full-rated flow plus the error at check flow.

d. Overcharges. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter, or other similar reasons, the amount of the overcharge shall be adjusted, refunded, or credited to the customer. The utility shall not be required to adjust, refund, or credit the customer's bill for a period of more than five years unless a different time period is ordered by the commission.

e. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter, or other similar reasons, the amount of the undercharge may be billed to the customer. The period for which the utility may adjust for the undercharge shall not exceed five years unless otherwise ordered by the commission. The maximum back bill will not exceed the dollar amount equivalent to the tariffed rate for like charges (e.g., usage-based, fixed, or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the commission.

f. Credits and explanations. Credits due to a customer because of meter inaccuracies, errors in billing, or misapplication of rates shall be separately identified.

**19.4(14) Refusal or disconnection of service.** A customer, as defined in subrule 19.1(2), may be refused or disconnected from service in accordance with tariffs that are consistent with these rules.

a. The utility shall give written notice of pending disconnection except as specified in paragraph 19.4(14) "b." The notice shall set forth the reason for the notice and final date by which the account is to be settled or specific action taken. The notice is considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice is considered provided when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing. The date for disconnection of service shall be not less than 12 days after the notice is provided. The date for disconnection of service for customers on shorter billing intervals under subrule 19.3(5) shall not be less than 24 hours after the notice is posted at the service premises.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for disconnection of service. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes shall be concurrent.

- b. Service may be disconnected without notice:
  - (1) In the event of a condition determined by the utility to be hazardous.
  - (2) In the event of customer use of equipment in a manner that adversely affects the utility's equipment or the utility's service to others.
  - (3) In the event of tampering with the equipment furnished and owned by the utility. For the purposes of this subrule, a broken or absent meter seal alone shall not constitute tampering.
  - (4) In the event of unauthorized use.
- c. Service may be disconnected or refused after proper notice:
  - (1) For violation of or noncompliance with the utility's rules on file with the commission.
  - (2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way that are specified to be furnished, in the utility's rules filed with the commission, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the commission.
  - (3) For failure of the customer to permit the utility reasonable access to the utility's equipment.
- d. Service may be refused or disconnected after proper notice for nonpayment of a bill or deposit, except as restricted by subrules 19.4(15) and 19.4(16), provided that the utility has complied with the following provisions when applicable:
  - (1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal;
  - (2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities available. Customers billed more frequently than monthly pursuant to subrule 19.3(5) shall be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices shall include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each utility representative must provide the representative's name and have immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.
  - (3) The summary of the rights and responsibilities must be approved by the commission. Any utility that does not use the standard form set forth below for customers billed monthly shall submit to the commission electronically its proposed form for approval. A utility billing a combination customer for both gas and electric service may modify the standard form to replace each use of the word "gas" with the words "gas and electric" in all instances.

**CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF  
OF GAS SERVICE FOR NONPAYMENT**

**1. What can I do if I receive a notice from the utility that says my gas service will be shut off because I have a past due bill?**

- a. Pay the bill in full;
- b. Enter into a reasonable payment plan with the utility (see #2 below);
- c. Apply for and become eligible for low-income energy assistance (see #3 below);
- d. Give the utility a written statement from a doctor or public health official stating that shutting off your gas service would pose an especial health danger for a person living at the residence (see #4 below); or
- e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

**2. How do I go about making a reasonable payment plan? (Residential customers only)**

- a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, the utility may offer you a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.

b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.

c. If you do not make the payments you promise, the utility may shut off your utility service on one day's notice unless all the money you owe the utility is paid or you enter into another payment agreement.

**3. How do I apply for low income energy assistance? (Residential customers only)**

a. Applications are taken at your local community action agency. If you are unsure where to apply, call 211 or 800.244.7431, or visit [hhs.iowa.gov/programs/programs-and-services/liheap](https://hhs.iowa.gov/programs/programs-and-services/liheap). To prevent disconnection, contact the utility prior to disconnection of your service.

b. To avoid disconnection, you must apply for energy assistance or weatherization before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

c. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1. Between November 1 and April 1, the utility will delay disconnection of your service for 30 days once you notify the utility that you are applying for energy assistance or weatherization assistance, to allow you time to obtain assistance. Only one 30-day delay is required during the moratorium period.

**4. What if someone living at the residence has a serious health condition? (Residential customers only)**

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your utility service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility office within five days of when your doctor or public health official notifies the utility of the health condition; otherwise, your utility service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if full payment or a payment agreement has not been made.

**5. What should I do if I believe my bill is not correct?**

You may dispute your utility bill. You must tell the utility that you dispute the bill. You must pay the part of the bill you think is correct. If you do this, the utility will not shut off your service for up to 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Commission for assistance in resolving the dispute. (See #9 below.)

**6. When can the utility shut off my utility service because I have not paid my bill?**

a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m., Monday through Friday.  
b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.  
c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

g. If one of the heads of household is a service member deployed for military service, utility service cannot be shut off during the deployment or within 90 days after the end of deployment. In order for this exception to disconnection to apply, the utility must be informed of the deployment prior to disconnection. However, you will still owe the utility for service used during this time.

**7. How will I be told the utility is going to shut off my gas service?**

a. You must be given a written notice at least 12 days before the utility service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The utility must also try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door or another conspicuous place of your residence to tell you that your utility service will be shut off.

**8. If service is shut off, when will it be turned back on?**

a. The utility will turn your service back on if you pay the whole amount you owe or agree to a reasonable payment plan. The service shall be restored for 30 days if you provide the utility with medical verification from a doctor or public health official of an especial danger to health within 14 days of a shut off for nonpayment.

b. If you make your payment during the utility's regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility must do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. The fee may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

**9. Is there any other help available besides my utility?**

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Commission toll-free at 877.565.4450. You may also write the Iowa Utilities Commission at 1375 E. Court Avenue, Des Moines, Iowa 50319-0069, or by email at [customer@iuc.iowa.gov](mailto:customer@iuc.iowa.gov). Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid, and may contact Legal Aid at 800.532.1275.

(4) When disconnecting service to a residence, the utility has made a diligent attempt to contact, by telephone or in person, the customer to inform the customer of the pending disconnection and the customer's rights and responsibilities. During the period from November 1 through April 1, if the attempt at customer contact fails, the premises shall be posted at least one day prior to disconnection with a notice informing the customer of the pending disconnection and rights and responsibilities available to avoid disconnection.

If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the utility shall make a diligent attempt to contact the landlord of the rental unit, if known, to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord shall also be informed of the date when service may be disconnected, which will be provided at least 48 hours prior to disconnection of service to a tenant.

If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection must be posted, at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

(5) Disputed bill. If the customer has received notice of disconnection and has a dispute concerning a bill for natural gas service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. A utility shall delay disconnection for nonpayment of the disputed bill for up to 45 days after the providing of the bill if the customer pays the undisputed amount. The 45 days may be extended if requested of the utility by the commission in the event the customer files a written complaint with the commission in compliance with 199—Chapter 6.

(6) Disconnection and reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during the utility's normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable

efforts shall be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts shall be made to reconnect the customer not later than 11 a.m. the next day.

(7) Severe cold weather. A disconnection may not take place where gas is used as the only source of space heating or to control or operate the only space heating equipment at a residence when the actual temperature or the 24-hour forecast of the National Weather Service for the residence's area is predicted to be 20 degrees Fahrenheit or colder. If the utility has properly posted a disconnect notice but is precluded from disconnecting service because of severe cold weather, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the residence's area rises above 20 degrees Fahrenheit and is forecasted to remain above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is otherwise entitled to postponement of disconnection.

(8) Medical stay. Disconnection of a residential customer shall be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises. An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances that indicate a severe or hazardous health situation.

The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

Verification shall postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection pursuant to paragraph 19.4(14)“f.”

(9) Winter energy assistance. If between November 1 through April 1 the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, there shall be no disconnection of service for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection shall not take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the utility by the community action agency as eligible for either the low-income home energy assistance program or weatherization assistance program. A utility may develop an incentive program to delay disconnection on April 1 for customers who make payments throughout the November 1 through April 1 period. All such incentive programs shall be set forth in tariffs approved by the commission.

(10) Deployment. If the utility is informed that one of the heads of household, as defined in Iowa Code section 476.20, is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

e. Abnormal gas consumption. A customer who is subject to disconnection for nonpayment of bill, and who has gas consumption that appears to the customer to be abnormally high, may request the utility to provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. The utility shall provide assistance by discussing patterns of gas usage that may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance that may be available to the customer.

f. A utility may disconnect gas service after 24-hour notice (and without the written 12-day notice) for failure of the customer to comply with the terms of a payment agreement.

g. Prior to November 1, utilities will mail customers a notice describing the availability of winter energy assistance funds and the application process. The notice must be of a type size that is easily legible and conspicuous and contain the information set out by the state agency administering the assistance program.

**19.4(15)** *Insufficient reasons for denying service.* The following do not constitute sufficient cause for refusal of service to a customer:

- a. Delinquency in payment for service by a previous occupant of the premises to be served.
- b. Failure to pay for merchandise purchased from the utility.
- c. Failure to pay for a different type or class of utility service.
- d. Failure to pay the bill of another customer as guarantor thereof.
- e. Failure to pay the back bill provided in accordance with paragraph 19.4(13) "b" (slow meters).
- f. Failure to pay adjusted bills based on the undercharges set forth in paragraph 19.4(13) "e."
- g. Failure of a residential customer to pay a deposit during the period November 1 through April 1 for the location at which the customer has been receiving service in the customer's name.
- h. Delinquency in payment for service by an occupant, if the customer applying for service is creditworthy and able to satisfy any deposit requirements.
- i. Delinquency in payment for service arising more than ten years prior, as measured from the most recent of:
  - (1) The last date of service for the account giving rise to the delinquency,
  - (2) Physical disconnection of service for the account giving rise to the delinquency, or
  - (3) The last voluntary payment or voluntary written promise of payment made by the customer, if made before the ten-year period described in this paragraph has otherwise lapsed.

**19.4(16)** *When disconnection prohibited.*

a. No disconnection may take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

b. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

**19.4(17)** *Change in character of service.* The following shall apply to a material change in the character of gas service:

a. *Changes under the control of the utility.* The utility shall make such changes only with the approval of the commission and after adequate notice to the customers (paragraph 19.7(6) "a").

b. *Changes not under control of the utility or customer.* Utilities will adjust appliances to attain the proper combustion of the gas supplied. Due consideration shall be given to the gas heating value and specific gravity (paragraph 19.7(6) "b").

c. *Appliance adjustment charge.* Utilities will make any necessary adjustments to the customer's appliances without charge and shall conduct the adjustment program with a minimum of inconvenience to the customers.

**19.4(18)** *Customer complaints.* Utilities will investigate promptly and thoroughly and keep a record of written complaints and all other reasonable complaints received by it from its customers in regard to safety, service, or rates, and the operation of its system that will enable it to review and analyze its procedures and actions. The record shall show the name and address of the complainant, the date and nature of the complaint, and its disposition and the date thereof. All complaints caused by a major outage or interruption shall be summarized in a single report.

a. Tariffs will include a concise, fully informative procedure for the resolution of customer complaints.

b. Reasonable steps will be taken to ensure that customers unable to travel are not denied the right to be heard.



c. The final step in a complaint hearing and review procedure shall be a filing for commission resolution of the issues.

This rule is intended to implement Iowa Code sections 476.2, 476.6, 476.8, 476.20 and 476.54.

**199—19.5(476) Engineering practice.**

**19.5(1) *Requirement for good engineering practice.*** The gas plant of the utility shall be constructed, installed, maintained, and operated in accordance with accepted good engineering practice in the gas industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

**19.5(2) *Standards incorporated by reference.***

a. The design, construction, operation, and maintenance of gas systems and liquefied natural gas facilities shall be in accordance with the following standards where applicable:

(1) Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports, 49 CFR Part 191.

(2) Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards, 49 CFR Part 192.

(3) Liquefied Natural Gas Facilities: Federal Safety Standards, 49 CFR Part 193.

(4) Drug and Alcohol Testing, 49 CFR 199.

(5) At railroad crossings, the engineering standards for pipelines found in 199—Chapter 42.

b. The following publications are adopted as standards of accepted good practice for gas utilities:

(1) National Fuel Gas Code, NFPA 54/ANSI Z223.1, published 2024.

(2) Standard for Fire Safety Criteria for Manufactured Home Installations, Sites, and Communities, NFPA 501A, published 2025.

**19.5(3) *Adequacy of gas supply.*** The natural gas regularly available from supply sources supplemented by production or storage capacity must be sufficiently large to meet all reasonable demands for firm gas service.

**19.5(4) *Gas transmission and distribution facilities.*** The utility's gas transmission and distribution facilities shall be designed, constructed and maintained as required to reliably perform the gas delivery burden placed upon them. Utilities will be capable of emergency repair work on a scale consistent with its scope of operation and with the physical conditions of its transmission and distribution facilities.

In appraising the reliability of the utility's transmission and distribution system, the commission will consider, as principal factors, the condition of the physical property and the size, training, supervision, availability, equipment and mobility of the maintenance forces.

**19.5(5) *Inspection of gas plant.*** Utilities will adopt and follow a program of inspection of its gas plant in order to determine the necessity for replacement and repair. The frequency of the various inspections shall be based on the utility's experience and accepted good practice. Utilities will keep sufficient records to give evidence of compliance with its inspection program.

**199—19.6(476) Metering.**

**19.6(1) *Inspection and testing program.*** Each utility shall adopt a written program for the inspection and testing of its meters to determine the necessity for adjustment, replacement or repair. The frequency of inspection and methods of testing shall be based on the utility's experience, manufacturer's recommendations, and accepted good practice. The commission considers the publications listed in subrule 19.6(3) to be representative of accepted good practice. Each utility shall maintain inspection and testing records for each meter and associated device until three years after its retirement.

**19.6(2) *Program content.*** The written program shall, at minimum, address the following subject areas:

a. Classification of meters by capacity, type, and any other factor considered pertinent.

b. Checking of new meters for acceptable accuracy before being placed in service.

c. Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments, or repairs, and including meters removed from service for any reason.

d. Periodic calibration or testing of devices or instruments used by the utility to test meters.

- e. Leak testing of meters before return to service.
- f. The limits of meter accuracy considered acceptable by the utility.
- g. The nature of meter and meter test records maintained by the utility.

**19.6(3) *Accepted good practice.*** The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

- a. American National Standard for Gas Displacement Meters (500 Cubic Feet Per Hour Capacity and Under), ANSI B109.1, published April 15, 2019, reaffirmed April 16, 2024.
- b. American National Standard for Diaphragm Type Gas Displacement Meters (Over 500 Cubic Feet Per Hour Capacity), ANSI B109.2, published March 16, 2020, reaffirmed July 3, 2025.
- c. American National Standard for Rotary Type Gas Displacement Meters, ANSI B109.3, published February 5, 2019, reaffirmed April 16, 2024.
- d. Measurement of Gas Flow by Turbine Meters, ANSI/ASME MFC-4M-1986, reaffirmed 2025.
- e. Orifice Metering of Natural Gas and Other Related Hydrocarbon Fluids, API MPMS Chapter 14.3, Part 1 (R2017), Part 2 (R2024), Part 3 (R2021), and Part 4 (R2026).

**19.6(4) *Meter adjustment.*** All meters and associated metering devices, when tested, will be adjusted as closely as practicable to the condition of zero error.

**19.6(5) *Request tests.*** Upon request by a customer, a utility shall test the meter for that customer but need not test more frequently than once in 18 months.

A written report of the test results shall be mailed to the customer within ten days of the completed test, and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted.

If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer \$25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

**19.6(6) *Referee tests.*** A customer or utility may request a referee test. The commission will conduct a referee test if no such test of the customer's meter has occurred in the 18 months prior to the request and the customer has submitted a \$30 deposit to the utility. A customer's request to the commission will indicate whether the deposit has been paid.

Within five days of receipt of the written request and confirmation of payment, the commission shall forward the deposit to the utility and notify the utility of the requirement for a test. The utility shall, within 30 days after notification of the request, schedule the date, time, and place of the test with the commission and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments made pursuant to subrule 19.4(13). The commission will issue its report within 15 days after the test is conducted, with a copy to the customer and the utility.

**19.6(7) *Condition of meter.*** No meter that is known to be mechanically defective, has an incorrect correction factor, or has not been tested and adjusted, if necessary, in accordance with paragraphs 19.6(2) "b," "c," and "e," shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the gas requirements of the customer.

## **199—19.7(476) Standards of quality of service.**

**19.7(1) *Purity.*** All gas supplied to customers shall be substantially free of impurities that may cause corrosion of mains or piping or from corrosive or harmful fumes when burned in a properly designed and adjusted burner. If the utility receives gas from a source other than an interstate transmission pipeline, or a pipeline that is subject to gas quality specifications defined by a tariff, the utility must take additional steps to ensure gas purity in the system.

**19.7(2) *Pressure limits.*** The maximum allowable operating pressure for a low-pressure distribution system shall not be so high as to cause the unsafe operation of any connected and properly adjusted low-pressure gas-burning equipment.

**19.7(3) Adequacy for pressure.** Each utility shall have a substantially accurate knowledge of the pressures inside its piping. Periodic pressure measurements shall be taken during periods of high demand at remote locations in distribution systems to determine the adequacy of service. Records of such measurements including the date, time, and location of the measurement shall be maintained not less than two years.

**19.7(4) Standards for pressure measurements.**

*a. Secondary standards.* Each utility shall own or have access to a dead weight tester that is maintained in an accurate condition.

*b. Working standards.* Each utility must have or have access to manometers, laboratory quality indicating pressure gauges, and field-type dead weight pressure gauges as necessary for the proper testing of the indicating and recording pressure gauges used in determining the pressure on the utility's system. Working standards must be checked periodically by comparison with a secondary standard.

**19.7(5) Handling of standards.** Extreme care must be exercised in the handling of standards to ensure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

**19.7(6) Heating value.**

*a. Awareness.* Each utility shall have a substantially accurate knowledge of the heating value of the gas being delivered to customers at all times.

*b. Natural and LP gas.* The heating value of natural gas and undiluted, commercially pure LP gas is not considered to be under the control of the utility. Utilities will determine the allowable range of monthly average heating values within which its customers' appliances may be expected to function properly without repeated readjustment of the burners. If the monthly average heating value is above or below the limits of the allowable range for three successive months, the customers' appliances must be readjusted in accordance with paragraph 19.4(17) "c."

*c. Renewable natural gas (RNG).* The heating value of gas supplied from an RNG facility is considered within the control of the RNG supplier. The average daily heating value of mixed gas in a distribution system shall be at least 95 percent of that normally delivered by the pipeline supplier. RNG producers are responsible for ensuring the gas produced from the RNG facility is compatible to meet these heating requirements.

*d. Peak shaving or other mixed gas.* The heating value of gas in a distribution system that includes gas from LP or LNG peak shaving facilities, or gas from a source other than a pipeline supplier, is considered within the control of the utility. The average daily heating value of mixed gas shall be at least 95 percent of that normally delivered by the pipeline supplier. All mixed gas shall have a specific gravity of less than 1.000, and heating value shall not be so high as to cause improper operation of properly adjusted customer equipment.

*e. Heating value determination and records.* Unless acceptable heating value information is available for all periods from other sources, including the pipeline supplier, utilities will have a method by which the heating value of the gas in a distribution system can be accurately determined. The type, accuracy, operation, and location of equipment, and the accuracy of computation methods, shall be in accordance with accepted industry practices and equipment manufacturer's recommendations, subject to review by the commission.

**19.7(7) Interruptions of service.**

*a.* Each utility shall make reasonable efforts to avoid interruptions of service, but when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety. Records will be maintained for not less than two years of interruptions of service required to be reported pursuant to subrule 19.16(1). Utilities will periodically review these records to determine steps to be taken to prevent recurrence.

*b.* Planned interruptions shall be made at a time that will not cause unreasonable inconvenience to customers. Interruptions shall be preceded by adequate notice to those who will be affected.

**199—19.8(476) Safety.**

**19.8(1) *Acceptable standards.*** As criteria of accepted good safety practice, the commission will use the applicable provisions of the standards incorporated by reference in subrule 19.5(2).

**19.8(2) *Protective measures.*** Utilities will exercise reasonable care to reduce hazards inherent in connection with utility service to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public, fitted to the size and type of its operations. Utilities will give reasonable assistance to the commission in the investigation of the cause of failures and in the determination of suitable means of preventing failures and will maintain a summary of all incidents that require notification pursuant to subrule 19.16(1) arising from its operations.

**19.8(3) *Turning on gas.*** Each utility upon the installation of a meter and turning on gas or the act of turning on gas alone shall take the necessary steps to assure itself that there exists no flow of gas through the meter, which is a warning that the customer's piping or appliances are not safe for gas turn on (Ref: Sec. 8.2.3 and Annex D, ANSI Z223.1/NFPA 54-2018).

**19.8(4) *Gas leaks.*** A report of a gas leak shall be considered an emergency requiring immediate attention.

**19.8(5) *Odorization.*** Any gas distributed to customers through gas mains or gas services or used for domestic purposes in compressor plants, which does not naturally possess a distinctive odor to the extent that its presence in the atmosphere is readily detectable at all gas concentrations of one-fifth of the lower explosive limit and above, shall have an odorant added to it to make it so detectable. Odorization is not necessary, however, for such gas as is delivered for further processing or use where the odorant would serve no useful purpose as a warning agent. Utilities will test the gas to ensure the odor meets the standards of subrule 19.5(2). Prompt remedial action shall be taken if odorization levels do not meet the prescribed limits for detectability.

**19.8(6) *Burial near electric lines.*** Each pipeline will be protected from damage or introduction of current from an electrical fault by installing it with at least 12 inches of clearance from buried electrical conductors or by other means if the clearance is not possible.

**19.8(7) *Compliance.*** Utilities are to correct all identified instances of noncompliance no later than 12 months from receiving a notice letter from the commission. If such corrective actions cannot be taken within that time frame, the utility shall notify the commission and provide a reasoning as to why such actions will take longer and the additional steps, if any, the utility is undertaking to maintain public health and safety in the meantime. If the utility disputes the commission's findings, the utility shall file a response with the commission within 30 days of such notification, explaining its belief why the findings have not occurred.

**199—19.9(476) Purchased gas adjustment (PGA).**

**19.9(1) *PGA clause.*** Pursuant to Iowa Code section 476.6(11), PGAs shall be computed separately for each customer classification or grouping previously approved by the commission and will use the same unit of measure as the utility's tariffed rates. PGAs shall be calculated using factors filed in annual or periodic filings according to the following formula:

$$PGA = \frac{(C \times Rc) + (D \times Rd) + (Z \times Rz) + Rb + E}{S}$$

PGA is the purchased gas adjustment per unit.

S is the anticipated yearly gas commodity sales volume for each customer classification or grouping.

C is the volume of applicable commodity purchased for each customer classification or grouping required to meet sales, S, plus the expected lost and unaccounted for volumes.

Rc is the weighted average of applicable commodity prices or rates, including appropriate hedging tools costs, to be in effect September 1 corresponding to purchases C.

D is the total volume of applicable entitlement reservation purchases required to meet sales, S, for each customer classification or grouping.

Rd is the weighted average of applicable entitlement reservation charges to be in effect September 1 corresponding to purchases D.

Z is the total quantity of applicable storage service purchases required to meet sales, S, for each customer classification or grouping.

Rz is the weighted average of applicable storage service rates to be in effect September 1 corresponding to purchases Z.

Rb is the adjusted amount necessary to obtain the anticipated balance for the remaining PGA year calculated by taking the anticipated PGA balance divided by the forecasted volumes, including storage, for one or more months of the remaining PGA year.

E is the per unit overcollection or undercollection adjustment as calculated under subrule 19.9(6).

The components of the formula shall be determined as follows for each customer classification or grouping:

a. The actual sales volumes S for the prior 12-month period ending May 31, with the necessary degree-day adjustments, and further adjustments approved by the commission. Unless a utility receives prior commission approval to use another methodology, a utility shall use the same weather normalization methodology used in its prior approved PGA. The source of the heating degree days (HDDs) used in the utility's weather normalization calculation shall be the state climatologist of Iowa.

b. The annual expected lost and unaccounted for factors shall be calculated by determining the actual difference between sales and purchase volumes for the 12 months ending May 31 or from the current annual IG-1 filing, but in no case will this factor be less than 0.

c. The purchases C, D, and Z as necessary to comply with subrule 19.9(1).

d. The PGAs shall be adjusted prospectively to reflect the final decision issued by the commission in a periodic review proceeding.

**19.9(2) Annual PGA filing.** Each utility shall file on or before August 1 of each year, for the commission's approval, a PGA for the 12-month period beginning September 1 of that year.

a. The annual filing shall restate each factor of the formula stated in subrule 19.9(1).

b. The annual filing shall be based on customer classifications and groupings previously approved by the commission unless new classifications or groupings are proposed.

c. The annual filing shall include all worksheets and detailed supporting data used to determine the PGA volumes and factors, along with an explanation of the calculations for each factor. Information already on file with the commission may be incorporated by reference in the filing.

**19.9(3) Periodic changes to PGA clause.** Periodic PGA filings shall be based on the PGA customer classifications and groupings previously approved by the commission. Changes in the customer classification and grouping on file are not automatic and require prior approval by the commission.

a. Periodic filings shall include all worksheets and detailed supporting data used to determine the amount of the adjustment.

b. Changes in factor S or C may not be made in periodic purchased gas filings. A change in factor D or Z may be made in periodic filings and will be deemed approved if it conforms to the annual purchased gas filing or if it conforms to the principles set out in subrule 19.9(5).

c. Utilities shall automatically implement all PGA changes that result from changes in Rc, Rd, or Rz and will concurrently notify the commission with adequate information to calculate and support the change. The PGA shall be calculated separately for each customer classification or grouping.

d. Unless otherwise ordered by the commission, a utility's PGA rate factors shall be adjusted as purchased gas costs change and shall recover from the customers only the actual costs of purchased gas and other currently incurred charges associated with the delivery, inventory, or reservation of natural gas. Such periodic changes shall become effective with usage on or after the date of change.

**19.9(4) Factor Rb.** Each utility has the option of filing an Rb calculation with its October-January PGA filings but shall file an Rb calculation with its February filing and subsequent monthly filings in the PGA year. If the anticipated PGA balance represents costs in excess of revenues, factor Rb shall be assigned a positive value; if the anticipated balance represents revenues in excess of costs, factor Rb shall be assigned a negative value.

**19.9(5) Allocations of changes in contract pipeline transportation capacity obligations.** Any change in contractual pipeline transportation capacity obligations to transportation or storage service providers serving Iowa shall be reported to the commission within 30 days of receipt. The change must

be applied on a pro-rata basis to all customer classifications or groupings, unless another method has been approved by the commission. Where a change has been granted as a result of the utility's request based on the needs of specified customers, that change may be allocated to the specified customers. Where the commission has approved anticipated sales levels for one or more customer classifications or groupings, those levels may limit the pro-rata reduction for those classifications or groupings.

**19.9(6) *Reconciliation of underbillings and overbillings.*** The utility shall file with the commission on or before October 1 of each year a PGA reconciliation for the 12-month period that began on September 1 of the previous year. This reconciliation will be the actual net invoiced costs of purchased gas and appropriate financial hedging tools costs less the actual revenue billed through its PGA clause net of the prior year's reconciliation dollars for each customer classification or grouping. Actual net costs for purchased gas shall be the applicable invoice costs from all appropriate sources associated with the time period of usage.

Negative differences in the reconciliation are considered overbilling by the utility, and positive differences are considered underbilling. This reconciliation shall be filed with all worksheets and detailed supporting data for each particular PGA clause. Penalty purchases shall only be includable where the utility clearly demonstrates a net savings.

*a.* Annual reconciliation filings will include the following information concerning the hedging tools used by the utility:

(1) The volume of physical gas being hedged by the utility and the strategies used by the utility for hedging.

(2) The reason each hedging strategy was undertaken (e.g., to hedge storage gas, a floating price contract).

(3) A statement as to how each hedging strategy was consistent with the utility's natural gas procurement plan.

(4) An explanation as to why the utility believes each hedging strategy was in the best interest of general system customers.

(5) A detailed explanation of the instruments used to implement each hedging strategy (e.g., fixed-price purchases, future contracts, basis swaps, fixed-price swaps, call options, put options, option collars).

(6) The amount of all commissions paid and to whom those payments were made.

(7) The amount of money or other collateral held in margin accounts or provided to counterparties as credit support for hedging transactions.

(8) The amount of all other third-party administrative or contracting costs paid and to whom those costs were paid.

(9) The name of each hedging counterparty and the amount of money paid to or received from each counterparty with respect to hedging (e.g., option premiums, financial settlement of gains or losses).

(10) Detailed reports or schedules of each hedging strategy, including the following information for each hedging instrument entered into by the utility:

1. The type of hedging instrument.

2. The date on which the hedging instrument was entered into by the utility.

3. The name of the counterparty with whom the hedging instrument was entered into.

4. The notional quantity of natural gas associated with the hedging instrument.

5. The notional delivery period associated with the hedging instrument.

6. The total amount of gains or losses realized by the utility on the hedging instrument.

7. For each futures contract or fixed-price purchase or sale, the fixed price paid or received by the utility and the final settlement price for the futures contract.

8. For each swap contract, the fixed price or index price paid by the utility, the index price or fixed price received by the utility, and the final settlement price of each applicable index referenced in the swap contract.

9. For each option contract, the underlying futures contract or index price referenced in the option contract, the strike price for the option, the premium paid or received by the utility for the option, and the final settlement price for the futures contract or index price referenced in the option.

10. For any other hedging instruments, relevant economic terms, conditions, reference prices, and other factors to support calculations of gains or losses associated with such instruments.

11. For the total natural gas volumes hedged during the PGA year, the fully hedged price of gas and the price if the gas had not been hedged.

b. Underbillings will be collected through ten-month adjustments to the appropriate PGA. The underbilling generated from each PGA clause shall be divided by the anticipated sales volumes for the prospective ten-month period beginning November 1 (based upon the sales determination in subrule 19.9(1)).

The quotient, determined on the same basis as the utility's tariff rates, shall be added to the PGA for the prospective ten-month period beginning November 1.

c. Overbillings will be refunded to the customer classification or grouping from which they were generated. Overbillings will be divided by the annual cost of purchased gas subject to recovery for the 12-month period that began the prior September 1 for each PGA clause and applied as follows:

(1) If the net overbilling from the PGA reconciliation exceeds the applicable percentage of the annual cost of purchased gas subject to recovery for a specific customer classification or grouping, the utility will file a proposed refund plan that includes its interest calculations, its plan for refunding the overbilling either by bill credit or check, and the date it proposes to implement the refund. The minimum amount to be refunded by check is \$10. Interest shall be calculated on amounts exceeding the applicable percentage from the PGA year midpoint to the date of refunding. The interest rate shall be the dealer commercial paper rate (90-day, high-grade unsecured notes) quoted in the "Money Rates" section of the Wall Street Journal on the last working day of August of the current year.

(2) If the net overbilling from the PGA reconciliation does not exceed the applicable percentage of the annual cost of purchased gas subject to recovery for a specific customer classification or grouping, the utility may refund the overbilling by bill credit or check starting on the first day of billing in the November billing cycle of the current year, or the utility may refund the overbilling through ten-month adjustments to the particular PGA from which they were generated. The minimum amount to be refunded by check is \$10. This adjustment shall be determined by dividing the overcollection by the anticipated sales volume for the prospective ten-month period beginning November 1 as determined in subrule 19.9(1) for the applicable PGA clause. The quotient, determined on the same basis as the utility's tariff rates, shall be a reduction to that particular PGA for the prospective ten-month period beginning November 1.

(3) The overbilling percentage applicable to utilities serving fewer than 10,000 customers is 5 percent. For utilities serving 10,000 or more customers, the applicable percentage is 3 percent.

d. When a customer has reduced or terminated system supply service and is receiving transportation service, any liability for overcollections and undercollections shall be determined in accordance with the utility's gas transportation tariff.

**19.9(7) Refunds related to gas costs charged through the PGA.** The utility shall file a refund plan with the commission within 30 days of the receipt of any refund related to gas costs charged through the PGA.

a. Refunds will be provided to customers by bill credit or check in an amount equal to any refund, plus accrued interest, if the refund exceeds \$20 per average residential customer under the applicable customer classification or grouping. The utility may refund lesser amounts through the applicable customer classification or grouping or retain undistributed refund amounts in special refund retention accounts for each customer classification or grouping under the applicable PGA clause until such time as additional refund obligations or interest cause the average residential customer refund to exceed \$20. Any obligations remaining in the retention accounts on September 1 shall become a part of the annual PGA reconciliation.

b. The utility shall file with the refund plan the following information:

- (1) A statement of reason for the refund.
- (2) The amount of the refund with support for the amount.
- (3) The balance of the appropriate refund retention accounts.
- (4) The amount due under each customer classification or grouping.

- (5) The intended period of the refund distribution.
  - (6) The estimated interest accrued for each refund through the proposed refund period, with complete interest calculations and supporting data as determined in paragraph 19.9(7) “d.”
  - (7) The total amount to be refunded, the amount to be refunded per customer classification or grouping, and the refund per ccf or therm.
  - (8) The estimated interest accrued for each refund received and for each amount in the refund retention accounts through the date of the filing with the complete interest calculation and support as determined in paragraph 19.9(7) “d.”
  - (9) The total amount to be retained, the amount to be retained per customer classification or grouping, and the level per ccf or therm.
  - (10) The calculations demonstrating that the retained balance is less than \$20 per average residential customer with supporting schedules for all factors used.
- c. The refund to each customer will be determined by dividing the amount in the appropriate refund retention account, including interest, by the total ccf or therm of system gas consumed by affected customers during the period for which the refundable amounts are applicable and multiplying the quotient by the ccf or therms of system supply gas actually consumed by the customer during the appropriate period. The utility may use the last available 12-month period if the use of the actual period generating the refund is impractical. The utility shall file complete support documentation for all figures used.
  - d. The interest rate on refunds distributed under this subrule, compounded annually, shall be the dealer commercial paper rate (90-day, high-grade unsecured notes) quoted in the “Money Rates” section of the Wall Street Journal on the day the refund obligation vests. Interest shall accrue from the date the utility receives the refund or billing from the supplier or the midpoint of the first month of overcollection to the date the refund is distributed to customers.
  - e. The utility shall make a reasonable effort to forward refunds, by check, to eligible recipients who are no longer customers.
  - f. The minimum amount to be refunded by check is \$10.
- This rule is intended to implement Iowa Code section 476.6(11).

**199—19.10(476) Periodic review of gas procurement practices.**

**19.10(1) Procurement plan.** Pursuant to Iowa Code section 476.6(11), the commission shall periodically conduct a contested case proceeding for the purpose of evaluating the reasonableness and prudence of a utility’s natural gas procurement and contracting practices. In the years in which the commission does not conduct a contested case proceeding, the commission may require the utilities to file certain information for the commission’s review. In years in which the commission conducts a full proceeding, a utility shall file prepared direct testimony and exhibits in support of a detailed 12-month plan and a three-year natural gas procurement plan. A utility’s procurement plan shall be organized as follows and include:

- a. An index of all documents and information filed in the plan and identification of the commission files in which documents incorporated by reference are located.
- b. All contracts and gas supply arrangements executed or in effect for obtaining gas and all supply arrangements planned for the future 12-month and three-year periods.
- c. A description of the utility’s natural gas forecasting, procurement, and contracting practices; available supply options; and other available services (e.g., storage services, balancing services).
- d. An exhibit detailing the utility’s current, 12-month, and three-year forecasts of total annual throughput by customer class, peak day demand, and anticipated reserve margin on a PGA-year basis.
- e. An organizational description of the officer or division responsible for gas procurement and a summary of operating procedures and policies for procuring and evaluating gas contracts.
- f. A summary of the legal, regulatory, and commercial actions taken to minimize purchased gas costs.
- g. Copies of all studies or investigation reports supporting the utility’s testimony or materially considered by the utility in contracting decisions during the plan periods.



*h.* A complete list of all contracts in effect at the time of the procurement plan filing. The list shall include the contract term, the applicable service, and the contracted quantities.

*i.* A description of the supply options selected by the utility and an evaluation of the reasonableness and prudence of its contracting and procurement decisions. This evaluation should explain the relationship between forecast and procurement.

**19.10(2)** *Burden on the utility.* The utility has the burden to prove it is taking all reasonable actions to minimize its purchased gas costs.

**19.10(3)** *Disallowance of costs.* Purchased gas costs in excess of costs incurred under responsible and prudent policies and practices are disallowed. The PGA factor will be adjusted prospectively to reflect the disallowance.

**19.10(4)** *Executive summary.* On or before August 1 of each year, each natural gas utility shall file an executive summary and index of all standard and special contracts in effect for the purchase, sale or interchange of gas. The executive summary shall include the following information:

- a.* The contract number;
- b.* The start and end date;
- c.* The parties to the contract;
- d.* The total estimated dollar value of the contract;
- e.* A description of the type of service offered (including volumes and price).

This rule is intended to implement Iowa Code section 476.6(11).

#### **199—19.11(476) Flexible rates.**

**19.11(1)** *Purpose.* This rule is intended to allow gas utility companies to offer, at their option, incentive or discount rates to their sales and transportation customers.

**19.11(2)** *General criteria.*

*a.* Natural gas utility companies may offer discounts to individual customers, to selected groups of customers, or to an entire class of customers. However, discounted rates must be offered to all directly competing customers in the same service territory. Customers are direct competitors if they make the same end product (or offer the same service) for the same general group of customers. Customers that only produce component parts of the same end product are not directly competing customers.

*b.* In deciding whether to offer a specific discount, the utility shall evaluate the individual customer's, group's, or class's situation and perform a cost-benefit analysis before offering the discount.

*c.* Any discount offered should be such as to significantly affect the customer's or customers' decision to stay on the system or to increase consumption.

*d.* The consequences of offering the discount should be beneficial to all customers and to the utility. Other customers should not be at risk of loss as a result of these discounts; in addition, the offering of discounts shall in no way lead to subsidization of the discounted rates by other customers in the same or different classes.

**19.11(3)** *Tariffs.* If a company elects to offer flexible rates, the utility shall file for review and approval of tariff sheets specifying the general conditions for offering discounted rates. The tariff sheets shall include, at a minimum, the following criteria:

*a.* A cost-benefit analysis demonstrating that offering the discount will be more beneficial than not offering the discount.

*b.* The ceiling for all discounted rates shall be the approved rate on file for the customer's rate class.

*c.* The floor for the discount sales rates shall be equal to the cost of gas. Therefore, the maximum discount allowed under the sales or transportation tariffs is equal to the nongas costs of serving the customer.

*d.* No discount shall be offered for a period longer than five years unless the commission determines upon good cause shown that a longer period is warranted.

*e.* Discounts should not be offered if they will encourage deterioration in the load characteristics of the customer receiving the discount.

*f.* Customer charges may be discounted.

**19.11(4) Reporting.** Each natural gas utility electing to offer flexible rates shall file annual reports with the commission within 30 days of the end of each 12 months. Reports shall include the following information:

- a. Section 1 of the report concerns discounts initiated in the last 12 months, which shall include:
  - (1) The identity of the new customers (by account number, if necessary);
  - (2) The value of the discount offered;
  - (3) The cost-benefit analysis results;
  - (4) The cost of alternate fuels available to the customer, if relevant;
  - (5) The volume of gas sold to or transported for the customer in the preceding 12 months; and
  - (6) A copy of all new or revised flexible-rate contracts executed between the utility and its customers.
- b. Section 2 of the report relates to overall program evaluation. For all discounts currently being offered, the report shall include:
  - (1) The identity of each customer (by account number, if necessary);
  - (2) The total volume of gas sold or transported in the last 12 months to each customer at discounted rates, by month;
  - (3) The volume of gas sold or transported to each customer in the same 12 months of the preceding year, by month;
  - (4) The dollar value of the discount in the last 12 months to each customer, by month;
  - (5) The dollar value of volumes sold or transported to each customer for each of the previous 12 months; and
  - (6) If customer charges are discounted, the dollar value of the discount shall be reported separately.
- c. Section 3 of the report concerns discounts denied or discounts terminated. For all customers specifically evaluated and denied or having a discount terminated in the last 12 months, the report shall include:
  - (1) Customer identification (by account number, if necessary);
  - (2) The volume of gas sold or transported in the last 12 months to each customer, by month;
  - (3) The volume of gas sold or transported to each customer in the same 12 months of the preceding year, by month; and
  - (4) The dollar value of volumes sold or transported to each customer for each of the past 12 months.

d. No report is required if the utility had no customers receiving a discount during the relevant period and had no customers that were evaluated for the discount and rejected during the relevant period.

**19.11(5) Rate case treatment.** In a rate case, 50 percent of any identifiable increase in net revenues will be used to reduce rates for all customers; the remaining 50 percent of the identifiable increase in net revenues may be kept by the utility. If there is a decrease in revenues due to the discount, the utility's test year revenues will be adjusted to remove the effects of the discount by assuming that all sales or transportation services or customer charges were made at full tariffed rates for the customer class. Determining the actual amount will be a factual determination to be made in the rate case.

**199—19.12(476) Transportation service.**

**19.12(1) Purpose.** This subrule requires gas distribution utility companies to transport natural gas owned by an end user on a nondiscriminatory basis, subject to the capacity limitations of the specific system. "System capacity" means the maximum flow of gas the relevant portion of the system is capable of handling. Capacity availability is determined using the total current firm gas flow, including both system and transportation gas.

**19.12(2) End user rights.** The end user purchasing transportation services from the utility shall have the following rights and be subject to the following conditions:

- a. The end user has the right to receive, pursuant to agreement, 100 percent of the gas delivered by it or on its behalf to the transporting utility (adjusted for a reasonable volume of lost, unaccounted-for, and company-used gas).

b. The volumes that the end user is entitled to receive are subject to curtailment or interruption due to limitations in the system capacity of the transporting utility. Curtailment of the transportation volumes will take place according to the priority class, subdivision, or category that the end user would have been assigned if it were purchasing gas from the transporting utility.

c. During periods of curtailment or interruption, the end user is entitled to a credit equal to the difference between the volumes delivered to the utility and those received by the end user, adjusted for lost, unaccounted-for, and company-used gas.

d. The end user is responsible for all costs associated with any additional plant required for providing transportation services to the end user.

**19.12(3) *Transportation service charges.*** Transportation service shall be offered to at least the following classes:

a. Interruptible distribution service with system supply reserve.

b. Interruptible distribution service without system supply reserve.

c. Firm distribution service with system supply reserve.

d. Firm distribution service without system supply reserve.

**19.12(4) *Transportation service charges and rates.*** All rates and charges for transportation shall be based on the cost of providing the service.

a. "System supply reserve" service entitles the end user to return to the system service to the extent of the interstate pipeline capacity purchased. The charge will be at least equal to the administrative costs of monitoring the service, plus any other costs.

b. End users without system supply reserve service may only return to system service by paying an additional charge and are subject to the availability of adequate interstate pipeline capacity. An end user wishing to receive transportation service without system supply reserve must pay the utility for the discounted value of any contract between the utility and the end user remaining in effect at the time of beginning transportation service. The discounted values shall include all directly assignable and identifiable costs.

c. The utility may require a reconnection charge when an end user receiving transportation service without system supply reserve service requests to return to the system supply. The end user shall return to the system and receive service under the appropriate classification as determined by the utility.

d. The end user electing to receive transportation service shall pay reasonable rates for any use of the facilities, equipment, or services of the transporting utility.

**19.12(5) *Reporting requirements.*** A natural gas utility will provide a copy of information concerning transportation contracts upon request of the commission, commission staff, or the office of consumer advocate.

**19.12(6) *Written notice of risks.*** The utility must notify its large-volume users as defined in 19.13(1) contracting for transportation service in writing that unless the customer buys system supply reserve service from the utility, the utility is not obligated to supply gas to the customer. The notice must also advise the large-volume user of the nature of any identifiable penalties, any administrative or reconnection costs associated with purchasing available firm or interruptible gas, and how any available gas would be priced by the utility. The notice may be provided through a contract provision or separate written instrument. The large-volume user must acknowledge in writing that it has been made aware of the risks and accepts the risks.

**199—19.13(476) Certification of competitive natural gas providers and aggregators.**

**19.13(1) *Definitions.*** The following words and terms, when used in this rule, shall have the meanings indicated below:

"*Large-volume user*" means any end user whose usage exceeds 25,000 therms in any month or 100,000 therms in any consecutive 12-month period.

"*Small-volume user*" means any end user whose usage does not exceed 25,000 therms in any month and does not exceed 100,000 therms in any consecutive 12-month period.

“*Vehicle fuel provider*” or “*VFP*” means a competitive natural gas provider or aggregator as defined in Iowa Code section 476.86 that owns or operates facilities to sell natural gas as vehicle fuel to a retail end user.

**19.13(2) *General requirement to obtain certificate.*** A competitive natural gas provider (CNGP) shall not provide competitive natural gas services to an Iowa retail end user without a certificate approved by the commission pursuant to Iowa Code section 476.87.

**19.13(3) *Filing requirements and application process.***

*a.* Applications to provide service as a CNGP pursuant to Iowa Code sections 476.86 and 476.87 shall contain information to reasonably demonstrate that the applicant possesses the managerial, technical, and financial capability sufficient to obtain and deliver the services the CNGP or aggregator proposes to offer. Applications shall be filed pursuant to 199—Chapter 14. Application forms to provide competitive natural gas service to large-volume, small-volume, and VFPs can be accessed on the commission’s website, [iuc.iowa.gov](http://iuc.iowa.gov). All applications shall include, at a minimum, the following information:

(1) The legal name and all trade names under which the applicant will operate, a description of the business structure of the applicant, evidence of authority to do business in Iowa, and the applicant’s state of incorporation.

(2) Names, addresses, and telephone numbers of corporate officers responsible for the applicant’s operations in Iowa and a telephone number where the applicant can be contacted 24 hours a day.

(3) Identification of the states and jurisdictions in which the applicant or an affiliate is providing natural gas service.

(4) A commitment to comply with all the applicable conditions of certification contained in subrules 19.13(5) and 19.13(6) and acknowledgment that failure to comply with all the applicable conditions of certification may result in the revocation of the CNGP’s certificate.

*b.* A request for confidential treatment of the information required to obtain a CNGP certificate may be filed with the commission pursuant to rule 199—1.7(22).

*c.* An applicant shall notify the commission during the pendency of the certification request and after certification of any material change in the representations and commitments made in the application within 14 days of such change. Any new legal actions or formal complaints are considered material changes in the request.

**19.13(4) *Deficiencies and commission determination.*** Applications will be considered complete when all required items are submitted. Applicants will be notified of deficiencies and given 30 days to complete applications. Applications with deficiencies that are not cured within the 30-day period will be denied.

**19.13(5) *Conditions of certification.*** CNGPs shall comply with the conditions set out in this subrule. Failure to comply with the conditions of certification may result in revocation of the certificate.

*a. Unauthorized charges.* A CNGP shall not charge or attempt to collect any charges from end users for any competitive natural gas services or equipment used in providing competitive natural gas services not contracted for or otherwise agreed to by the end user.

*b. Notification of emergencies.* Upon receipt of information from an end user of the existence of an emergency situation with respect to delivery service, a CNGP shall immediately contact the appropriate utility whose facilities may be involved. The CNGP shall also provide the end user with the emergency telephone number of the utility.

*c. Reports to the commission.* Each CNGP shall file a report with the commission on April 1 of each year for the 12-month period ending December 31 of the previous year. The report shall be filed on forms provided by the commission, which can be accessed on the commission’s website, [iuc.iowa.gov](http://iuc.iowa.gov). This information may be filed with a request for confidentiality, pursuant to rule 199—1.7(22). For each utility distribution system, the report shall include, at a minimum, total monthly and annual sales volumes, total monthly revenues, and total number of customers served each month as of December 31 of the applicable year.

**19.13(6)** *Additional conditions applicable to CNGPs providing service to small-volume end users.* All CNGPs when providing service to small-volume natural gas end users shall be subject to the following conditions in addition to those listed under subrule 19.13(5):

*a. Customer deposits.* Compliance with the following provisions shall apply to customers whose usage does not exceed 2,500 therms in any month or 10,000 therms in any consecutive 12-month period.

Customer deposits – subrule 19.4(3).

Interest on customer deposits – subrule 19.4(4).

Customer deposit records – subrule 19.4(5).

Customer's receipt for a deposit – subrule 19.4(6).

Deposit refund – subrule 19.4(7).

Unclaimed deposits – subrule 19.4(8).

*b. Bills to end users.* A CNGP shall include on bills to end users all the information listed in this paragraph. The bill may be sent to the customer electronically at the customer's option.

(1) The period of time for which the billing is applicable.

(2) The amount owed for current service, including an itemization of all charges.

(3) Any past-due amount owed.

(4) The last date for timely payment.

(5) The amount of penalty for any late payment.

(6) The location for or method of remitting payment.

(7) A toll-free telephone number for the end user to call for information and to make complaints regarding the CNGP.

(8) A toll-free telephone number for the end user to contact the CNGP in the event of an emergency.

(9) A toll-free telephone number for the end user to notify the utility of an emergency regarding delivery service.

(10) The tariffed transportation charges and supplier refunds, where a combined bill is provided to the customer.

*c. Disclosure.* Each prospective end user must receive in writing, prior to initiation of service, all terms and conditions of service and all rights and responsibilities of the end user associated with the offered service. The information may be provided electronically, at the customer's option.

*d. Notice of service termination.* Notice shall be provided to the end user, the commission, and the utility at least 12 calendar days prior to service termination. If the notice of service termination is rescinded, the CNGP must notify the utility. CNGPs are prohibited from physically disconnecting the end user or threatening physical disconnection for any reason.

*e. Transfer of accounts.* CNGPs will not transfer the account of any end user to another supplier except with the consent of the end user and notice to the commission. This provision does not preclude a CNGP from transferring all or a portion of its accounts pursuant to a sale or transfer of all or a substantial portion of a CNGP's business in Iowa, provided that the transfer satisfies all of the following conditions:

(1) The transferee will serve the affected end users through a certified CNGP;

(2) The transferee will honor the transferor's contracts with the affected end users;

(3) The transferor provides written notice of the transfer to each affected end user prior to the transfer;

(4) Any affected end user is given 30 days to change supplier without penalty; and

(5) The transferor provides notice to the utility of the effective date of the transfer.

*f. Bond.* The commission may require the applicant to file a bond or other demonstration of its financial capability to satisfy claims and expenses that can reasonably be anticipated to occur as part of operations under its certificate, including the failure to honor contractual commitments. In determining the adequacy of the bond or demonstration, the commission shall consider the extent of the services to be offered, the size of the provider, and the size of the load to be served.

g. *Replacement cost for supply failure.* Each utility shall file for the commission's review tariffs establishing replacement cost for supply failure. Replacement cost revenue will be credited to the utility's system PGA.

**199—19.14(476) Customer contribution fund.**

**19.14(1) *Applicability and purpose.*** This rule applies to each gas utility as defined in Iowa Code section 476.1. Pursuant to Iowa Code section 476.66, each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

**19.14(2) *Notification.*** Each utility shall notify all customers of the customer contribution fund at least twice a year. Upon commencement of service and at least once a year, the notice will be mailed or personally delivered to all customers or provided by electronic means to those customers who have consented to receiving electronic notices. The other notice may be published in a local newspaper(s) of general circulation within the utility's service territory. At a minimum, the notice shall include:

- a. A description of the availability and the purpose of the fund;
- b. A customer authorization form that includes a monthly billing option and any other methods of contribution.

**19.14(3) *Methods of contribution.*** Contributions will be provided as monthly pledges, as well as one-time or periodic contributions. A pledge will not be construed to be a binding contract between the utility and the pledger. The pledge amount shall not be subject to late payment charges by the utility. Each utility may allow persons or organizations to contribute matching funds.

**19.14(4) *Annual report.*** On or before September 30 of each year, each utility shall file with the commission a report of all the customer contribution fund activity for the previous fiscal year, beginning July 1 and ending June 30, on a form provided by the commission that contains an accounting of the total revenues collected and all distributions of the fund.

**199—19.15(476) Reserve margin.**

**19.15(1) *Applicability.*** All gas utility companies may maintain a reserve of contract services in excess of their maximum daily system demand requirement and recover the cost of the reserve from their customers through the PGA.

**19.15(2) *Definitions.*** The following definitions apply to the terms as used in this rule:

*"Contract services"* refers to the amount of firm gas delivery capacity or delivery services contracted for use by a utility to satisfy its maximum daily system demand requirement, including the planned delivery capacity of the utility-owned liquefied natural gas facilities but excluding the delivery capacity of propane storage facilities.

*"Design day"* means reasonably anticipated colder-than-normal weather conditions during a 24-hour period beginning at 9 a.m.

*"Maximum daily system demand requirements"* means the maximum daily gas demand requirement that the utility forecasts to occur on behalf of its system firm sales customers under design day weather conditions. The maximum daily gas demand requirement forecast will be determined based upon an evaluation of historic usage levels of firm sales customers, adjusted for reasonably anticipated colder-than-normal weather conditions and other clearly identifiable factors that may contribute to the demand for gas by firm sales customers. The maximum daily system demand requirements shall be submitted for approval by the commission with the Annual PGA filing required by subrule 19.9(2).

**19.15(3) *Maximum daily system demand requirements of less than 25,000 Dth per day.*** A reserve margin of 9 percent or less in excess of the maximum daily system demand requirements will be presumed reasonable.

**19.15(4) *Maximum daily system demand requirements of more than 25,000 Dth per day.*** A reserve margin of 5 percent or less in excess of the maximum daily system demand requirements will be presumed reasonable.

**19.15(5) *Rebuttable presumption.*** All contract services in excess of an amount needed to meet the maximum daily system demand requirements plus the reserve are presumed to be unjust and

unreasonable unless a factual showing to the contrary is made during the periodic review of gas proceeding or in a proceeding specifically addressing the issue with an opportunity for an evidentiary hearing. All contract services less than an amount of the maximum daily system demand requirements plus the reserve are presumed to be just and reasonable unless a factual showing to the contrary can be made during the periodic review of gas proceeding or in a proceeding specifically addressing the issue with an opportunity for an evidentiary hearing.

**19.15(6) *Allocation of cost of the reserve.*** Fifty percent of the reserve cost shall be collected as a demand charge allocation to noncontractual firm customers. The remaining 50 percent shall be collected as a throughput charge on customers excluding transportation customers who have elected no system supply reserve.

**199—19.16(476) Incident notification and reports.**

**19.16(1) *Notification.*** Utilities will notify the commission immediately, or as soon as practical, of any incident involving the release of gas, failure of equipment, or interruption of facility operations, which results in any of the following:

- a. Any reportable incidents as defined in 49 CFR 191.3.
- b. An unplanned interruption of service to 50 or more customers.
- c. Evacuation of a school, hospital, health care facility, or event totaling 100 or more people.
- d. Rerouting of traffic or closing of a federal or state highway by public emergency responders.
- e. Traditional news media attention.
- f. Unintentional fire or explosion.
- g. Any other incident considered significant by the utility.

**19.16(2) *Reporting information.*** The utility shall notify the commission by email, as soon as practical, of any reportable incident at [dutyofficer@iuc.iowa.gov](mailto:dutyofficer@iuc.iowa.gov) or, when email is not available, by calling the commission duty officer at 515.745.2332. The person sending the email or the caller shall leave a call-back number for a person who can provide the following information:

- a. The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.
- b. The location of the incident.
- c. The time of the incident.
- d. The number of deaths or personal injuries and the extent of those injuries, if any.
- e. An initial estimate of damages.
- f. The number of services interrupted.
- g. A summary of the significant information available to the utility regarding the probable cause of the incident and extent of damages.
- h. Any oral or written report required by the U.S. Department of Transportation, the name of the person who made the oral report or prepared the written report, and when such a report was made.

**19.16(3) *Written incident reports.*** Within 30 days of the date of the incident, the utility shall file a written report with the commission that includes the information listed in subrule 19.16(2), the probable cause as determined by the utility, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available at a later date, the utility will timely file the information in a supplemental report. The utility will also provide the commission with copies of any written reports concerning an incident or safety-related condition filed with or submitted to the U.S. Department of Transportation or the National Transportation Safety Board.

**199—19.17(476) Quarterly reporting.**

**19.17(1) *Excavation damage with loss of gas.*** Utilities shall submit a quarterly report to the commission with information related to any excavation damages that resulted in a release of gas during the reporting period. This report must include the following information for each instance of excavation damage:

- a. Date of the damage.

- b. Address of the damage.
- c. Type of line damaged (service, main, or transmission).
- d. Name of the excavation companies involved.
- e. Name of the excavation equipment involved.
- f. One Call ticket number, if applicable.
- g. Any such other information as may be deemed pertinent on forms prescribed by the commission, which are located on the commission's website.

**19.17(2) *One Call ticket volume.*** Each quarter, utilities must report to the commission the total number of One Call tickets received during the reporting period.

**19.17(3) *Reporting period.*** Each quarterly report is due the fifteenth of the month following the end of the quarter.

- a. The first-quarter reporting period covers January 1 to March 31, with the quarterly report due on April 15.
- b. The second-quarter reporting period covers April 1 to June 30, with the quarterly report due on July 15.
- c. The third-quarter reporting period covers July 1 to September 30, with the quarterly report due on October 15.
- d. The fourth-quarter reporting period covers October 1 to December 31, with the quarterly report due on January 15 of the following year.

**199—19.18(476) Capital infrastructure investment automatic adjustment mechanism.**

**19.18(1) *Eligible capital infrastructure investment.*** A natural gas utility may file for commission approval of a capital infrastructure investment automatic adjustment mechanism to allow recovery of certain costs from customers. To be eligible for recovery through the capital infrastructure investment automatic adjustment mechanism, the costs shall either:

- a. Meet the following criteria:
  - (1) The costs are beyond the direct control of management;
  - (2) The costs are subject to sudden, important change in level;
  - (3) The costs are an important factor in determining the total cost of capital infrastructure investment to serve customers; and
  - (4) The costs are readily, precisely, and continuously segregated in the accounts of the utility; or
- b. Be for a capital infrastructure investment that:
  - (1) Does not serve to increase revenues by directly connecting the infrastructure replacement to new customers;
  - (2) Is in service but was not included in the gas utility's rate base in its most recent general rate case; and
  - (3) Replaces or modifies existing infrastructure required by state or local government action, to meet state or federal natural gas pipeline safety regulations, or to otherwise enhance safety as approved in advance by the commission. The utility shall make an annual filing with the commission to seek advance determination of projects that meet this criterion.

**19.18(2) *Determination of recovery factor.*** The utility may recover a rate of return and depreciation expense associated with eligible capital infrastructure investments described in subrule 19.18(1). The allowed rate of return will be the approved average cost of debt from the utility's most recent general gas or electric rate review proceeding before the commission. Depreciation expense shall be based upon the depreciation rates allowed by the commission in the utility's most recent general gas rate review proceeding before the commission.

**19.18(3) *Recovery procedures.***

- a. To recover capital infrastructure investment costs that meet the criteria in paragraph 19.18(1) "a" through an automatic adjustment mechanism, the utility will first obtain prior commission approval of the automatic adjustment mechanism. The utility will file the following information in support of the proposed automatic adjustment mechanism:



(1) A description of the capital infrastructure investment and the costs that are proposed to be recovered through the automatic adjustment mechanism;

(2) An explanation of why the costs of the capital infrastructure investment are beyond the control of the utility's management;

(3) An exhibit that shows the changes in level of the costs of the capital infrastructure investment that are proposed to be recovered, both historical and projected;

(4) An explanation of why these particular capital infrastructure investment costs are an important factor in determining the total cost of capital infrastructure investment to serve customers;

(5) A description of proposed recovery procedures, if different from the procedures described in paragraph 19.18(3) "c"; and

(6) The length of time that the automatic adjustment mechanism will be in place.

b. Recovery of capital infrastructure investment costs pursuant to paragraph 19.18(1) "b" may be made by the utility by filing a proposed tariff no later than April 1 of each year. Only one tariff filing to recover capital infrastructure investment costs shall be made in a 12-month period. The filing will include the following information in support of the proposed automatic adjustment rates:

(1) Proof that the capital infrastructure investment is a project that was approved in advance by the commission as specified in subparagraph 19.18(1) "b"(3).

(2) The location, description, and costs associated with the project.

(3) The cost of debt from the utility's most recent general gas or electric rate review proceeding before the commission and the applicable depreciation rates from the utility's most recent general gas rate review proceeding before the commission.

(4) The calculations showing the total costs that are eligible for recovery and the rates that are proposed to be implemented.

(5) Supporting documentation, including but not limited to work orders and journal entries, to the commission staff or the office of consumer advocate upon request.

c. The utility shall calculate the rates for the recovery of the capital infrastructure investment through the automatic adjustment mechanism over the 12-month period beginning from the effective date of the tariff unless otherwise ordered by the commission. The calculated rate shall include a reconciliation that reconciles the actual revenue recovered through the automatic adjustment mechanism with the costs of the eligible capital infrastructure investments proposed to be recovered over the previous collection period. Unless otherwise specified in an approved tariff, the capital infrastructure investment factor shall be recovered by a fixed monthly surcharge to customers, to be determined by totaling eligible investment costs for the prior calendar year, adjusted for the reconciliation amount, then dividing the total recovery amount among customer classes based upon the utility's most recent approved cost of service study, dividing the class recovery amounts by the number of months in the recovery period, and then dividing the assigned costs by the number of customers in each respective class. The recovery amount will be limited to annual depreciation plus a return on the undepreciated balance based on the cost of debt.

d. Recovery of a return on and return of capital infrastructure investment that is eligible for recovery pursuant to an automatic adjustment mechanism will continue until the effective date of temporary rates in a subsequent general rate proceeding or, if temporary rates are not implemented, until final rates approved by the commission in the utility's next general rate proceeding. To continue recovery, a utility shall file a proposed tariff each year. Once temporary or final rates are effective, the automatic adjustment mechanism will reset to zero. No more than five years of capital investment recovery will be allowed between general rate proceedings unless otherwise approved by the commission. A utility may continue recoveries allowed under this rule until the investments are fully depreciated or until the utility's next general rate proceeding.

These rules are intended to implement Iowa Code sections 476.2, 476.6, 476.8, 476.20, 476.54, 476.66, 476.86, and 476.87.

**ARC 0307D****UTILITIES COMMISSION[199]****Notice of Intended Action****Proposing rulemaking related to regulation of electric cooperatives and municipal electric utilities and providing an opportunity for public comment**

The Utilities Commission hereby proposes to rescind Chapter 27, “Regulation of Electric Cooperatives and Municipal Electric Utilities Under Iowa Code Chapter 476,” 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 chapter 476.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 476.

*Purpose and Summary*

Proposed Chapter 27 regulates electric cooperatives and municipal electric utilities. The Commission opened this docket in conjunction with the rulemakings in Docket Nos. RMU-2025-0019 and RMU-2025-0028, largely in order to promote conformity among the Commission’s chapters.

Proposed Chapter 27 contains the Commission’s procedure for electric cooperatives and municipal electric utilities operating in Iowa. The Commission issued an order commencing rulemaking on April 16, 2026. The order is available on the Commission’s electronic filing system, [efs.iowa.gov](https://efs.iowa.gov), under Docket No. RMU-2025-0027.

*Regulatory Analysis*

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on January 7, 2026. A public hearing was held on the following date(s):

- February 12, 2026

The public hearing was attended by the Office of Consumer Advocate, a division of the Iowa Department of Justice; Iowa Association of Electric Cooperatives (IAEC); Black Hills/Iowa Gas Utility Company, LLC d/b/a Black Hills Energy (Black Hills); MidAmerican Energy Company (MidAmerican); and Interstate Power and Light Company. Based on the written and oral comments received, the Commission modified proposed Chapter 27 to produce the version in this Notice of Intended Action.

*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*

No waiver provision is included in the proposed amendments because the Commission has a general waiver provision in rule 199—1.3(17A,474,476) that provides procedures for requesting a waiver.

*Public Comment*

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on June 16, 2026. Comments should be directed to:

IT Support  
Iowa Utilities Commission  
Phone: 515.725.7300  
Email: [ITSupport@iuc.iowa.gov](mailto:ITSupport@iuc.iowa.gov)

*Public Hearing*

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

|                               |                                                                                        |
|-------------------------------|----------------------------------------------------------------------------------------|
| June 18, 2026<br>9 to 11 a.m. | Commission Hearing Room<br>1375 East Court Avenue<br>Des Moines, Iowa<br>Also via Zoom |
|-------------------------------|----------------------------------------------------------------------------------------|

Persons who wish to make oral comments at the 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 the 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 199—Chapter 27 and adopt the following **new** chapter in lieu thereof:

CHAPTER 27  
REGULATION OF ELECTRIC COOPERATIVES AND MUNICIPAL  
ELECTRIC UTILITIES UNDER IOWA CODE CHAPTER 476

**199—27.1(476) General information.** Iowa Code section 476.2(1) provides that the Iowa utilities commission has authority to establish all needful, just and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties; the practice and procedure before it; and to the form, content and filing of reports, documents and other papers provided for in Iowa Code chapter 476 or in the commission's rules.

**27.1(1) Application of rules.** The rules apply to electric cooperatives and municipal electric utilities operating within the state of Iowa subject to Iowa Code sections 476.1A and 476.1B, and to the construction, operation, and maintenance of electric transmission lines to the extent provided in Iowa Code chapter 478, and supersede all tariffs on file with the commission that are in conflict with these rules.

**27.1(2) Regulation of electric cooperatives.** Iowa Code section 476.1A provides that electric cooperatives are not subject to the regulation of the commission, except for regulatory action pertaining to the following:

- a. Assessment of fees for the support of the commission and the office of consumer advocate pursuant to Iowa Code section 476.10.
- b. Safety standards and engineering standards.
- c. Assigned service areas, as set forth in Iowa Code sections 476.22 through 476.25.
- d. Public utility railroad crossings, as set forth in Iowa Code section 476.27.
- e. Filing of alternate energy purchase program plans with the commission, and offering such programs to customers, pursuant to Iowa Code section 476.47.
- f. Iowa Code sections 476.20(1) through 476.20(4), 476.21, 476.51, 476.56, 476.58, 476.62, and 476.66 and chapters 476A and 478, to the extent applicable.

**27.1(3) Regulation of municipal electric utilities.** Iowa Code section 476.1B provides that municipal electric utilities are not subject to regulation by the commission under Iowa Code chapter 476, except for regulatory action pertaining to the following:

- a. Assessment of fees for the support of the commission and the office of consumer advocate.
- b. Safety standards.
- c. Assigned areas of service as set forth in Iowa Code sections 476.22 through 476.26.
- d. Public utility railroad crossings, as set forth in Iowa Code section 476.27.
- e. An electric power agency as defined in Iowa Code chapter 28F and section 390.9 that includes as a member a city- or municipality-owned utility that builds transmission facilities after July 1, 2001, is subject to applicable transmission reliability rules or standards adopted by the commission for these facilities.
- f. Filing of alternate energy purchase program plans with the commission, and offering such programs to customers, pursuant to Iowa Code section 476.47.
- g. Iowa Code sections 476.20(1) through 476.20(4), 476.51, 476.56, 476.58, 476.62, and 476.66, as applicable.
- h. An electric utility subject to regulatory action pursuant to Iowa Code section 476.1A or 476.1B is subject to complaints and investigations as set forth in Iowa Code section 476.3, but only with regard to matters within the regulatory authority of the commission as set forth in Iowa Code sections 476.1A and 476.1B.

**27.1(4) Abbreviations.** The following abbreviations are used in this chapter where appropriate:

ANSI—American National Standards Institute, [www.ansi.org](http://www.ansi.org).

IEEE—Institute of Electrical and Electronics Engineers, [www.ieee.org](http://www.ieee.org).

NESC—National Electrical Safety Code.

NFPA—National Fire Protection Association, [www.nfpa.org](http://www.nfpa.org).

RUS—United States Department of Agriculture Rural Utilities Service, [www.rd.usda.gov/about-rd/agencies/rural-utilities-service](http://www.rd.usda.gov/about-rd/agencies/rural-utilities-service).

**27.1(5) Definitions.** The following words and terms, when used in these rules, have the meanings indicated below:

“*Capacity*” means the instantaneous rate at which energy can be delivered, received, or transferred, measured in kilowatts.

“*Complaint*” means a statement or question by any person, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or obligation of an electric cooperative or municipal electric utility.

“*Customer*” means any person, firm, association, or corporation; any agency of the federal, state, or local government; or any legal entity responsible by law for payment for the electric service or heat from the electric cooperative or municipal electric utility.

“*Delinquent*” or “*delinquency*” means an account for which a service bill or service payment agreement bill has not been paid in full on or before the last day for timely payment.

“*Distribution line*” means any single or multiphase electric power line operating at nominal voltage in either of the following ranges: 2,000 to 36,225 volts between ungrounded conductors or 1,155 to 20,914 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

*“Electric plant”* includes all real estate, fixtures, and property owned, controlled, operated, or managed in connection with or to facilitate production, generation, transmission, or distribution in providing electric service or heat by an electric utility.

*“Electric service”* means furnishing electricity to the public for compensation for use as heat, light, power, or energy.

*“Energy”* means electric energy measured in kilowatt hours.

*“Engineering standards”* means standards adopted by ANSI, IEEE, RUS, or comparable engineering organization or engineering standards adopted by the commission.

*“Major event”* means when an event results in extensive physical damage to transmission or distribution facilities within an electric cooperative or municipal electric utility’s operating area due to unusually severe and abnormal weather or event and:

1. Wind speed exceeds 90 mph for the affected area, or
2. One-half inch of ice is present and wind speed exceeds 40 mph for the affected area, or
3. 10 percent of the affected area total customer count is incurring a loss of service for a length of time to exceed five hours, or
4. 20,000 customers in a metropolitan area are incurring a loss of service for a length of time to exceed five hours, or
5. A regional transmission organization or independent system operator declares an energy emergency alert that the organization can no longer provide expected energy requirements or has lower than established reserves, implements procedures up to shedding load, or declares an Energy Emergency Alert Level 3 in compliance with North American Electric Reliability Corporation requirements.

*“Meter”* means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

*“Power”* means electric power measured in kilowatts.

*“Rates”* means the same as defined in Iowa Code section 384.80 and includes all charges or fees imposed or collected for the provision of or incidental to utility service.

*“Safety standard”* means applicable regulations promulgated by the United States Occupational Safety and Health Administration. Safety standards for electric utilities subject to Iowa Code section 476.1A also include outage notifications, safety standards contained in the National Electrical Safety Code, as published by IEEE, and electric safety standards approved by ANSI.

*“Secondary line”* means any single or multiphase electric power line operating at nominal voltage less than either 2,000 volts between ungrounded conductors or 1,155 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

*“Service limitation”* means the establishment of a limit on the amount of power that may be consumed by a residential customer through the installation of a service limiter device on the customer’s meter.

*“Tariff”* means the service classifications, rules, procedures, and policies filed with and approved by the commission.

*“Timely payment”* means a payment on a customer’s account made on or before the date shown on a current bill for service, or on a form that records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date that determines application of a late payment charge to the current bill or future collection efforts.

*“Transmission line”* means any single or multiphase electric power line operating at nominal voltages at or in excess of either 69,000 volts between ungrounded conductors or 40,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

*“Utility”* means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any facilities for furnishing electricity to the public for compensation.

**27.1(6)** *Electric cooperative service rules tariffs.* Electric cooperatives subject to the commission’s jurisdiction under Iowa Code section 476.1A shall maintain tariffs in the commission’s electronic filing system that are consistent with the rules in this chapter and that are approved by the commission.

*a.* Those portions of their tariff or tariff pages regarding matters over which the commission has jurisdiction are to be filed with strikethroughs for the language deleted and underlining of the language that is added.

*b.* Portions of electric cooperative tariffs that are nonjurisdictional are to be identified in the tariff.

*c.* An electric cooperative association may file a model tariff for commission approval that may be adopted by an electric cooperative with any revisions the electric cooperative proposes to the model tariff.

*d.* Any electric cooperative may concur with an approved model tariff on file with the commission. For any electric cooperative that chooses to concur, the commission shall acknowledge the electric cooperative's tariff as being in compliance.

*e.* Tariffs approved by the commission are to be made available to all customers.

**27.1(7)** *Municipal electric utilities service rules.* Municipal utilities service rules or other legally enforceable provisions are to be consistent with the provisions in this chapter and must be available to all customers.

**199—27.2(476) Assigned area of service and maps.**

**27.2(1)** *Service areas.* Service areas are defined by the boundaries on service area maps. Electronic maps are available for viewing on the commission's website or at the commission's offices during regular business hours. These service area maps are the official electric service territory maps pursuant to Iowa Code section 476.24.

**27.2(2)** *Modification of service area and answers.*

*a.* An exclusive service area is subject to modification through a contested case proceeding that may be commenced by filing a petition for modification of service area with the commission. The commission may commence a service area modification proceeding on its own motion. The commission may grant a modification if the modification promotes the public interest. In determining whether the modification is in the public interest, the commission will consider the factors described in Iowa Code section 476.25(1) and any other relevant factors.

*b.* Any electric cooperative or municipal electric utility may file a petition for modification of service area, which includes:

- (1) A legal description of the service area desired,
- (2) A designation of the utilities involved in each boundary section,
- (3) A justification for the proposed service area modification, including addressing the public interest,
- (4) A PDF (portable document format) map, an electronic file of the proposed service area boundaries, in a format designated by the commission, as described on the electronic filing system (EFS) homepage under EFS filing standards, and
- (5) A map showing the affected areas that complies with the map paragraph contained within this chapter is to be attached to the petition as an exhibit.

*c.* Electric cooperatives and municipal electric utilities may agree with other electric utilities to service territory modifications by contract pursuant to Iowa Code section 476.25(2). Contracts to be enforceable are to be approved by the commission.

**27.2(3)** *Certificate of authority.* A request for a service territory modification filed by an electric cooperative or municipal electric utility pursuant to this rule that would result in service to a customer by a public utility other than the public utility currently serving the customer will need a certificate of authority under Iowa Code section 476.23. Unless voluntarily agreed otherwise, the party currently serving the customer is to be paid a reasonable price for the facilities serving the customer.

**27.2(4)** *Maps.*

*a.* Each electric cooperative and municipal electric utility is to maintain a current map or set of maps showing the physical location of electric lines, stations, and electric transmission facilities for its service areas. The maps are to include the exact location of the following:

- (1) Generating stations, with capacity designation.
- (2) Purchased power supply points, with maximum contracted capacity designation.

- (3) Purchased power metering points if located at other than power delivery points.
- (4) Transmission lines, with size and type of conductor designation and operating voltage designation.
- (5) Transmission-to-transmission voltage transformation substations, with transformer voltage and capacity designation.
- (6) Transmission-to-distribution voltage transformation substations, with transformer voltage and capacity designation.
- (7) Distribution lines, with size and type of conductor designation, phase designation, and voltage designation.
- (8) All points at which transmission, distribution, or secondary lines of the utility cross Iowa state boundaries.
- (9) All current information required in Iowa Code section 476.24(1).
- (10) All county boundaries and county names.
- (11) Natural and artificial lakes that cover more than 50 acres and all rivers.
- (12) Any additional information required by the commission.
  - b. All maps, except those deemed confidential by the commission, are to:
    - (1) Be available for examination at the designated offices of the electric cooperative or municipal electric utility during regular office hours,
    - (2) Include clean, uniform lines to a scale of at least one inch per mile,
    - (3) Include a larger scale where it is necessary to clarify areas where there is a heavy concentration of facilities, and
    - (4) Ensure that cartographic details are clean cut, and the background contains little or no coloration or shading.

**199—27.3(476) Customer relations.**

**27.3(1)** *Notification to customers by bill insert at least annually.* Each electric cooperative or municipal electric utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached, and include the following statement: “If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Commission by calling 515.725.7300 or toll-free 877.565.4450; by writing to 1375 E. Court Ave., Des Moines, IA 50319-0069; by filling out the form at iuc.iowa.gov; or by email to customer@iuc.iowa.gov.” The utility may use different language with commission approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information required in this subrule.

**27.3(2)** *Payment agreements.*

a. *Availability of a first payment agreement.* When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the electric cooperative or municipal electric utility for residential utility service and is not in default of a payment agreement with the electric cooperative or municipal electric utility, an electric cooperative or municipal electric utility shall offer the customer an opportunity to enter into a reasonable payment agreement. The offer of a payment agreement is to be made prior to disconnection. The electric cooperative or municipal electric utility is not required to offer a customer who has been disconnected from service a payment agreement consistent with these rules, unless the utility did not comply with these rules prior to disconnection.

b. *Reasonableness.* Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The electric cooperative or municipal electric utility may require the person to confirm financial difficulty with an acknowledgment from the department of health and human services or another agency.

c. *Terms of payment agreements.*

(1) First payment agreement. The following conditions are to be offered to customers who have received a disconnection notice and are not in default of a payment agreement:

1. For customers who received a disconnection notice in conformance with these rules, an agreement with at least 12 even monthly payments is to be offered. A customer may pay off the delinquency early without incurring any prepayment penalties. A customer will not be charged interest, or a late payment charge, on a payment agreement where the customer is making payments consistent with the terms of the payment agreement, and the customer will not be required to pay a portion of the delinquent amount to enter into a payment agreement.

2. A provision for payment of the current amount owed by the customer is to be offered.

3. The electric cooperative or municipal electric utility may also require the customer to enter into a budget billing plan to pay the current bill.

4. When the customer makes the agreement in person, a signed copy of the agreement is to be provided to the customer.

5. The electric cooperative or municipal electric utility may offer the customer the option of making the agreement over the telephone or through electronic transmission.

6. When a payment agreement is made over the telephone or through electronic transmission, a written agreement reflecting the terms and conditions of the agreement is to be provided to the customer within three days of the date the oral or electronic agreement is entered into.

7. The document will be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage paid. If delivery is by other than U.S. mail, the document will be considered provided to the customer when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing.

8. The payment agreement is deemed accepted by the customer unless the customer notifies the utility otherwise within ten days from the date the document is provided. The address and toll-free telephone number where a qualified representative can be reached is to be included in the payment agreement.

9. Once the first payment required by the agreement is made by the customer or on behalf of the customer, the oral or electronic agreement is deemed accepted by the customer.

10. Each customer entering into a first payment agreement is allowed at least one late payment that is four days or less beyond the due date for payment, and the first payment agreement remains in effect.

11. The initial payment is due on the due date for the next regular bill.

(2) Second payment agreement. A second payment agreement is to be offered to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement.

1. The second payment agreement will be for a term at least as long as the term of the first payment agreement.

2. The customer is to pay for current service in addition to the monthly payments.

3. The customer may be required to make the first payment up front as a condition of entering into the second payment agreement.

4. The electric cooperative or municipal electric utility may also require the customer to enter into a budget billing plan to pay the current bill.

(3) Additional payment agreements. The electric cooperative or municipal electric utility may offer additional payment agreements to the customer.

- d. Refusal by electric cooperative or municipal electric utility.* A customer may offer the electric cooperative or municipal electric utility a proposed payment agreement. If the electric cooperative or municipal electric utility and the customer do not reach an agreement, the electric cooperative or municipal electric utility may refuse the offer orally, but the electric cooperative or municipal electric utility will provide a written refusal to the customer, stating the reason for the refusal, within three days of the oral notification. The written refusal is considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal is considered provided to the customer when handed to the



customer or when delivered to the last-known address of the customer, or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing.

*e. Customer request for assistance.* A customer may ask the commission for assistance in working out a reasonable payment agreement. The request for assistance is to be made to the commission within ten days after the written refusal is provided and disconnection will not take place during the commission's review.

**27.3(3) Bill payment terms.** The bill is to be considered provided to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill is to be considered provided when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing. An account shall not be delinquent until 20 days have passed since the bill was provided to the customer. For customers on more frequent billing intervals, an account shall not be delinquent until five days have passed since the bill was provided to the customer. A late payment charge cannot be assessed if payment is received within 20 days of the date the bill is provided.

*a.* The date of delinquency for all residential customers or other customers whose consumption is less than 3,000 kWh per month is changeable for cause; such as but not limited to 15 days from the approximate date each month upon which income is received by the person responsible for payment. Thirty days beyond the date of delinquency is the maximum delay allowed. Thirty days beyond the date of previous bill preparation is the maximum delay allowed.

*b.* In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge is limited to 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge.

*c.* If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment is to be credited pro rata between the bill for utility services and related taxes.

*d.* Each account is allowed not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules are to include that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The utility's rules are to state how the customer is notified that the eligibility has been used. Complete forgiveness has no effect upon the credit rating of the customer or collection of late payment charges.

**27.3(4) Meter testing standards.** Electric cooperatives and municipal electric utilities are to establish written meter testing standards and procedures for customers who have complaints about the accuracy of the customer's meter. The meter testing standards are to be made available to a customer upon request.

#### **199—27.4(476) Disconnection of service.**

**27.4(1) Disconnection procedures and notice.** Electric cooperatives and municipal electric utilities may only disconnect service to customers in compliance with the following procedure and requirements:

*a.* Service may be disconnected without notice:

(1) In the event of a condition on the customer's premises determined by the utility to be hazardous.

(2) In the event of customer use of equipment in a manner that adversely affects the utility's equipment or the utility's service to others.

(3) In the event of tampering with the equipment furnished and owned by the utility. A broken or absent meter seal alone does not constitute tampering.

(4) In the event of unauthorized use.

*b.* The electric cooperative or municipal electric utility shall give written notice of pending disconnection, except as specified in paragraph 27.4(1)"a." The notice will include the reason for the notice and the final date by which the account is to be settled or specific action taken. The notice is to be addressed to the customer's last-known address and deposited in the U.S. mail with postage

prepaid. If delivery is by other than U.S. mail, the notice is to be delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing. The date for disconnection of service is not to be less than 12 days after the notice is provided. The date for disconnection of service for customers on shorter billing intervals is not to be less than 24 hours after the notice is posted at the service premises.

c. Where more than one cause of disconnection exists, one written notice is to be given that includes all reasons for the notice. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes run concurrently.

d. Service may be disconnected after proper notice:

(1) For violation of or noncompliance with the utility's rules.

(2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way that are specified to be furnished, in the utility's rules filed with the commission, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the commission.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

e. Service may be disconnected after proper notice for nonpayment of a bill or deposit, provided that the electric cooperative or municipal electric utility has complied with the following provisions:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal.

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities set out in subrule 27.4(2). Customers billed more frequently than monthly are to be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each electric cooperative or municipal electric utility representative provides the representative's name and has immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) A service limitation policy shall include the following sentence: "Service limitation: We have adopted a limitation of service policy for customers who otherwise could be disconnected. Contact our business office for more information or to learn if you qualify."

(4) When disconnecting service to a residence, a diligent attempt is to be made to contact, by telephone or in person, the customer to inform the customer of the pending disconnection and the customer's rights and responsibilities. Between November 1 and April 1, if the attempt at customer contact fails, the premises are to be posted at least one day prior to disconnection with a notice informing the customer of the pending disconnection and a copy of the rights and responsibilities available to avoid disconnection.

1. If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the electric cooperative or municipal electric utility is to make a diligent attempt to contact the landlord of the rental unit, if known, to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord is to be informed of the date when service may be disconnected. The electric cooperative or municipal electric utility will make a diligent attempt to inform the landlord at least 48 hours prior to disconnection of service to a tenant.

2. If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the electric cooperative or municipal electric utility to contain residential units affected by disconnection are to be posted at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

3. If the customer has received notice of disconnection and has a dispute concerning a bill for electric service, the electric cooperative or municipal electric utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. Disconnection for nonpayment of the disputed bill is delayed for up to 45 days after the providing of the bill if the customer pays the undisputed amount. The 45 days may be extended by up to 60 days if requested of the utility by the commission in the event the customer files a written complaint with the commission in compliance with 199—Chapter 6.

*f.* Disconnection and reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts are to be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts are to be made to reconnect the customer not later than 11 a.m. the next day.

*g.* Severe cold weather. A disconnection is not to take place where electricity is used as the only source of space heating or to control or operate the only space heating equipment at a residence when the actual temperature or the 24-hour forecast of the National Weather Service for the residence's area is predicted to be 20 degrees Fahrenheit or colder. If the electric cooperative or municipal electric utility has properly posted a disconnect notice but is precluded from disconnecting service because of severe cold weather, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the residence's area rises above 20 degrees Fahrenheit and is forecasted to remain above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is otherwise entitled to postponement of disconnection.

*h.* Medical stay. Disconnection of a residential customer will be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises.

(1) An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances that indicate a severe or hazardous health situation.

(2) The electric cooperative or municipal electric utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

(3) Verification will postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service is to be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection.

*i.* Winter energy assistance. If between November 1 through April 1 the electric cooperative or municipal electric utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, service is not to be disconnected for 30 days from the date the electric cooperative or municipal electric utility is notified to allow the customer time to obtain assistance. Disconnection of service is not allowed from November 1 through April 1 for a resident who is a head of household and who has been certified to the electric cooperative or municipal electric utility by the community action agency as eligible for either the low-income home energy assistance program or the weatherization assistance program.

j. Deployment. If the electric cooperative or municipal electric utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

k. Abnormal electric consumption. A customer who is subject to disconnection for nonpayment of a bill, and who has electric consumption that appears to the customer to be abnormally high, may request the utility provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. Assistance will be provided by the electric cooperative or municipal electric utility by discussing patterns of electric usage that may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance available to the customer.

l. An electric cooperative or municipal electric utility may disconnect electric service after 24-hour notice (and without the written 12-day notice) for failure of the customer to comply with the terms of a payment agreement.

m. Prior to November 1, a notice describing the availability of winter energy assistance funds and the application process is to be mailed to customers. The notice is to be of a type size that is easily legible and conspicuous and contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. An electric cooperative or municipal electric utility serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

**27.4(2) Notice of customer rights and responsibilities.** The standard form of the summary of the rights and responsibilities to be provided to customers is set out below, and will be provided by an electric cooperative or municipal electric utility with all disconnection notices. A nonstandard rights and responsibilities notice may be used with commission approval. The standard customer rights and responsibilities notice is as follows:

**CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF ELECTRIC SERVICE FOR NONPAYMENT**

**1. What can I do if I receive a notice from the utility that says my service will be shut off because I have a past due bill?**

- a. Pay the bill in full;
- b. Enter into a reasonable payment plan with the utility (see #2 below);
- c. Apply for and become eligible for low-income energy assistance (see #3 below);
- d. Give the electric cooperative or municipal electric utility a written statement from a doctor or public health official stating that shutting off your electric service would pose an especial health danger for a person living at the residence (see #4 below); or
- e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

**2. How do I go about making a reasonable payment plan? (Residential customers only)**

- a. Contact the electric cooperative or municipal electric utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, you are to be offered a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.
- b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.
- c. If you do not make the payments you promise, the utility may shut off your electric service on one day's notice, unless all the money you owe the utility is paid or you enter into another payment agreement.

**3. How do I apply for low-income energy assistance? (Residential customers only)**

- a. Applications are taken at your local community action agency. If you are unsure where to apply, call 211 or 800.244.7431, or visit [hhs.iowa.gov/programs/programs-and-services/liheap](https://hhs.iowa.gov/programs/programs-and-services/liheap). To prevent disconnection, contact the utility prior to disconnection of your service.

b. To avoid disconnection, you must apply for energy assistance or weatherization before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

c. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1. Between November 1 and April 1, the utility will delay disconnection of your service for 30 days once you notify the utility that you are applying for energy assistance or weatherization assistance, to allow you time to obtain assistance. Only one 30-day delay is required during the moratorium period.

**4. What if someone living at the residence has a serious health condition? (Residential customers only)**

Contact the electric cooperative or municipal electric utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your electric service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the electric cooperative's or municipal electric utility's office within five days of when your doctor or public health official notifies the utility of the health condition; otherwise, your electric service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

**5. What should I do if I believe my bill is not correct?**

You may dispute your bill by telling the electric cooperative or municipal electric utility that you dispute the bill and paying the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the electric cooperative or municipal electric utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Commission for assistance in resolving the dispute (see #9 below).

**6. When can the electric cooperative or municipal electric utility shut off my electric service because I have not paid my bill?**

a. Your electric cooperative or municipal electric utility can shut off service between the hours of 6 a.m. and 2 p.m. Monday through Friday.

b. The electric cooperative or municipal electric utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.

c. The electric cooperative or municipal electric utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The electric cooperative or municipal electric utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the electric cooperative or municipal electric utility cannot shut off your service from November 1 through April 1. However, you will still owe the electric cooperative or municipal electric utility for the service used during this time.

f. The electric cooperative or municipal electric utility will not shut off your service if you have notified the electric cooperative or municipal electric utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

g. If one of the heads of household is a service member deployed for military service, electric service cannot be shut off during the deployment or within 90 days after the end of deployment. In order for this exception to disconnection to apply, the electric cooperative or municipal electric utility will need to be informed of the deployment prior to disconnection. However, you will still owe the electric cooperative or municipal electric utility for service used during this time.

**7. How will I be told the electric cooperative or municipal electric utility is going to shut off my service?**

a. You must be given a written notice at least 12 days before the electric service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The electric cooperative or municipal electric utility must try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the electric cooperative or municipal electric utility cannot reach you by telephone or in person, the electric cooperative or municipal electric utility will put a written notice on the door of or another conspicuous place at your residence to tell you that your electric service will be shut off.

**8. If service is shut off, when will it be turned back on?**

a. The electric cooperative or municipal electric utility will turn your service back on if you pay the whole amount you owe. The service shall be restored for 30 days if you provide the utility with medical verification from a doctor or public health official of an especial danger to health within 14 days of a shut off for nonpayment.

b. If you make your payment during regular business hours, or by 7 p.m. for electric cooperatives or municipal electric utilities permitting such payment or other arrangements after regular business hours, the electric cooperative or municipal electric utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility is to do it by 11 a.m. the next day.

c. The electric cooperative or municipal electric utility may charge you a fee to turn your service back on. That fee may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

**9. Is there any other help available besides my electric cooperative or municipal electric utility?**

If the electric cooperative or municipal electric utility has not been able to help you with your problem, you may contact the Iowa Utilities Commission toll-free at 877.565.4450. You may also write the Iowa Utilities Commission at 1375 E. Court Ave., Des Moines, IA 50319-0069, or email [customer@iuc.iowa.gov](mailto:customer@iuc.iowa.gov). Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid and may contact Iowa Legal Aid at 800.532.1275.

**27.4(3)** *When disconnection is not allowed.*

a. No disconnection may take place from November 1 through April 1 for a resident who has been certified to the utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

b. If the electric cooperative or municipal electric utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

**27.4(4)** *Servicing of utilization control equipment.* Each electric cooperative or municipal electric utility is to service and maintain any equipment it uses on a customer's premises and correctly set and keep in proper adjustment any utility-owned thermostats, clocks, relays, time switches or other devices that control the customer's service in accordance with the provisions in the utility's schedules.

**27.4(5)** *Customer complaints.* A utility will promptly and thoroughly investigate all complaints concerning its practices, facilities, or service. The electric cooperative or municipal electric utility is to keep such records of customer complaints as will enable it to review and analyze its procedures and actions.

a. Each electric cooperative and municipal electric utility is to develop a fully informative procedure for the resolution of customer complaints.

b. The utility is to take reasonable steps to ensure that customers unable to travel are not denied the right to be heard.

c. The final step in a complaint review procedure, if the utility and customer are not able to agree on a resolution of the complaint, is a filing for commission resolution of the issues if the commission determines it has jurisdiction.

**27.4(6)** *Limitation of service.* The electric cooperative or municipal electric utility may adopt a policy for service limitation at a customer's residence as a measure to be taken in lieu of disconnection of service to the customer. The service limiter policy is to contain the following:

- a. No activation without the customer's agreement.
- b. A requirement for default on all payment agreements the customer has qualified for and agreed to.
- c. Usage of a minimum of 3,600 watts. If the service limiter policy provides for different usage levels for different customers, specific nondiscriminatory criteria for determining the usage levels are set out. Electric-heating residential customers may have their service limited if otherwise eligible, but consumption limits are to be set at a level that allows customers to continue to heat their residences. For purposes of this rule, "electric heating" means heating by means of a fixed-installation electric appliance that serves as the primary source of heat and not, for example, one or more space heaters.
- d. A provision that, if the minimum usage limit is exceeded such that the limiter function interrupts service, the service limiter function is to be capable of being reset manually by the customer, or the service limiter function will reset itself automatically within 15 minutes after the interruption. In addition, the service limiter function may also be capable of being reset remotely. If the option of resetting the meter remotely is available, the utility is to provide a 24-hour toll-free number for the customer to notify the electric cooperative or municipal electric utility that the limiter needs to be reset and the meter is to be reset immediately following notification by the customer. If the remote reset option is used, the meter is to be capable of being reset manually by the customer or the service limiter function will reset itself automatically within 15 minutes after the interruption.
- e. There may be no disconnect, reconnect, or other charges associated with service limiter interruptions or restorations.
- f. A provision that, upon installation of a service limiter or activation of a service limiter function on the meter, the electric cooperative or municipal electric utility is to provide the customer with information on the operation of the limiter, including how it can be reset, and information on what appliances or combination of appliances can generally be operated to stay within the limits imposed by the limiter.
- g. A provision that the service limiter function of the meter is to be disabled no later than the next working day after the residential customer has paid the delinquent balance in full.
- h. A service limiter customer that defaults on the payment agreement is subject to disconnection after a 24-hour notice.

#### **199—27.5(476) Engineering standards.**

**27.5(1)** *Requirement for good engineering practice.* The electric plant of the electric cooperative or municipal electric utility shall be constructed, installed, maintained, and operated in accordance with accepted good engineering practice in the electric industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

**27.5(2)** *Standards incorporated by reference.* Applicable provisions in the publications listed below as standards of accepted good practice unless otherwise ordered by the commission. The standards listed below are recommended for use by municipal electric utilities.

- a. Iowa Electrical Safety Code, as defined in 199—Chapter 25.
- b. National Electrical Code, ANSI/NFPA 70-2026, published October 3, 2025.
- c. IEEE C57.13.1-2017, IEEE Guide for Field Testing of Relaying Current Transformers, as published October 31, 2018; and IEEE PC57.13.3, IEEE Approved Draft Guide for Grounding of Instrument Transformer Secondary Circuits and Cases, as published March 10, 2026.
- d. American National Standard for Electric Power Systems and Equipment Voltage Ratings (60 Hertz), ANSI C84.1-2020, published September 3, 2020.
- e. Recommended Practice for System Grounding of Industrial and Commercial Power Systems, IEEE 3003.1-2019, published August 9, 2019.
- f. IEEE 1159-2019, IEEE Recommended Practice for Monitoring Electric Power Quality, as published August 13, 2019.
- g. IEEE 519-2022, IEEE Standard for Harmonic Control in Electric Power Systems, as published August 5, 2022.

- h.* At railroad crossings, the engineering standards for pipelines rule found in 199—Chapter 42.
- i.* Iowa Stray Voltage Guide, located at [www.iowastrayvoltageguide.com](http://www.iowastrayvoltageguide.com), published July 2014.
- j.* American National Standard for Electric Meters—Code for Electricity Metering, ANSI C12.1-2026, published February 3, 2026.
- k.* IEEE Guide for Electric Power Distribution Reliability Indices, IEEE 1366-2022, published November 22, 2022.

**199—27.6(476) Safety.**

**27.6(1)** *Interconnection compliance.* Each electric cooperative and municipal electric utility shall comply with commission rules for standards for interconnection, safety, and operating reliability under this subrule and rule 199—15.9(476).

**27.6(2)** *Protective measures.* Each electric cooperative and municipal electric utility shall exercise reasonable care to reduce those hazards inherent in connection with its electric service and to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public and fitted to the size and type of its operations.

**27.6(3)** *Accident investigation and prevention.* Electric cooperatives and municipal electric utilities are to give reasonable assistance to the commission in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

**27.6(4)** *Reportable accidents.* Electric cooperatives and municipal electric utilities are to maintain a summary of all reportable accidents, as defined in rule 199—25.5(476,478), arising from operations.

**27.6(5)** *Grounding of secondary distribution system.* Unless otherwise specified by the commission, each electric cooperative and municipal electric utility is to comply with, and encourage customers to comply with, the applicable provisions of the acceptable standards for the grounding of secondary circuits and equipment.

*a.* Ground connections should be tested for resistance at the time of installation. Each electric cooperative and municipal electric utility are to keep a record of all ground resistance measurements.

*b.* Each electric cooperative and municipal electric utility is to establish a program of inspection so that all artificial grounds installed are inspected within reasonable periods of time.

**199—27.7(476) Customer contribution fund.**

**27.7(1)** *Applicability and purpose.* This rule applies to each electric cooperative and municipal electric utility as defined in Iowa Code sections 476.1A and 476.1B. Pursuant to Iowa Code section 476.66, each electric cooperative or municipal electric utility is to maintain a program plan to assist the electric cooperative's or municipal electric utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

**27.7(2)** *Notification.* Notice of the customer contribution fund is to be given to all customers at least twice a year. Upon commencement of service and at least once a year, the notice is to be mailed or personally delivered to all customers, or provided by electronic means to those customers who have consented to receiving electronic notices. The other notice may be published in a local newspaper(s) of general circulation within the service territory of the electric cooperative or municipal electric utility. A utility serving fewer than 6,000 customers may publish its semiannual notices locally in a free newspaper, utility newsletter or shopper's guide instead of a newspaper. At a minimum, the notice is to include:

- a.* A description of the availability and the purpose of the fund.
- b.* A customer authorization form that includes a monthly billing option and methods of contribution.

**27.7(3)** *Methods of contribution.* Contribution methods may include monthly pledges, as well as one-time or periodic contributions. A pledge by a customer or other party is not a binding contract between the electric cooperative or municipal electric utility and the pledger. Delayed contributions are not subject to late payment charges. Each electric cooperative or municipal electric utility may allow persons or organizations to contribute matching funds.



**27.7(4) *Annual report.*** On or before September 30 of each year, each electric cooperative or municipal electric utility is to file with the commission a report of all the customer contribution fund activity for the previous fiscal year from July 1 through June 30, on a form provided by the commission that contains an accounting of the total revenues collected and all distributions of the fund.

**199—27.8(476,478) *Service reliability requirements for electric utilities.*** Each electric cooperative and municipal electric utility is to adopt and have approved by its board of directors or governing authority a reliability plan. The reliability plan is to be updated not less than annually. A copy of the EC-1 (Annual Report) or ME-1, as applicable, is to be filed with the commission for informational purposes.

**199—27.9(476,478) *Notification of outages.***

**27.9(1) *Notification.*** The notification requirements in this rule are for the timely collection of electric outage information that may be useful to emergency management agencies in providing for the safety and welfare of individual Iowa citizens. Each electric cooperative and municipal electric utility shall notify the commission when it is projected that an outage may result in a loss of service for more than six hours and the outage meets one of the following criteria:

*a.* Loss of service for more than six hours to substantially all of a municipality, including the surrounding area served by the same electric cooperative or municipal electric utility. An electric cooperative or municipal electric utility may use loss of service within the utility's service territory to 75 percent or more of customers within a municipality, including the surrounding area served by the utility, to meet this criterion;

*b.* A major event as defined in this chapter, except for notifications of emergency alerts from regional transmission organizations or independent system operators; or

*c.* Any other outage considered significant by the electric cooperative or municipal electric utility. This includes loss of service for more than six hours to significant public health and safety facilities known to the electric cooperative or municipal electric utility at the time of the notification.

**27.9(2) *Information about outages.***

*a.* Notification shall be provided regarding outages that meet the requirements of subrule 27.9(1) by notifying the commission duty officer by email at [dutyofficer@iuc.iowa.gov](mailto:dutyofficer@iuc.iowa.gov) or, in appropriate circumstances, by telephone at 515.745.2332. Notification shall be made at the earliest possible time after it is determined the event may be reportable and should include the following information, as available:

(1) The general nature or cause of the outage;

(2) The area affected;

(3) The approximate number of customers that have experienced a loss of electric service as a result of the outage;

(4) The time when service is estimated to be restored; and

(5) The name of the electric cooperative or municipal electric utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the outage. The notice should be supplemented as more complete or accurate information is available.

*b.* The electric cooperative or municipal electric utility is to provide to the commission updates of the estimated time when service will be restored to all customers able to receive service or of significantly changed circumstances, unless service is restored within one hour of the time initially estimated.

*c.* The electric cooperative or municipal electric utility is to notify the commission once service is fully restored to all customers after an outage meeting the requirements of subrule 27.9(1).

**27.9(3) *Planned interruptions.*** Planned interruptions by electric cooperatives and municipal electric utilities are to be made at a time that will not cause an unreasonable inconvenience to customers. Adequate notice should be provided to customers that will be affected when a planned interruption lasts longer than one hour.

**199—27.10(476) Electric vehicle charging service.** The requirements in rule 199—20.20(476) regarding electric vehicle charging stations apply to electric cooperatives and municipal electric utilities.

**199—27.11(476) Exterior flood lighting.**

**27.11(1) Newly installed lighting.** All newly installed exterior flood lighting owned by an electric cooperative or municipal electric utility are to be solid-state lighting or lighting with equivalent or better energy efficiency.

**27.11(2) In-service lighting replacement schedule.** In-service lighting is to be replaced with solid-state lighting or lighting with equivalent or better energy efficiency when worn out due to ballast, lamp, or fixture failure or for any other reason, such as vandalism or storm damage. Electric cooperatives and municipal electric utilities are to include in their annual report to be filed pursuant to 199—Chapter 23 a report stating the progress in converting to higher pressure sodium lighting or lighting with equivalent or higher energy efficiency.

**27.11(3) Efficacy standards.** Lighting other than solid-state has equivalent or better efficacy if one or more of the following can be established:

- a. For fixtures, the mean lumens-per-watt lamp rating is greater than 100;
- b. The new lighting uses no more energy per installation than comparable, suitably sized solid-state; or
- c. The new lighting luminaires have a mean efficacy rating equal to or greater than 100 lumens per watt according to a Department of Energy (DOE) Lighting Facts label, testing under the DOE Commercially Available LED Product Evaluation and Reporting Program (CALiPER), Design Lights Consortium (DLC) or any other testing agency that follows Illuminating Engineering Society of North America LM-79-19, as approved May 14, 2019, test procedures.

These rules are intended to implement Iowa Code sections 476.1A, 476.1B, 476.2, and 476.20.

**ARC 0305D**

## **UTILITIES COMMISSION[199]**

### **Notice of Intended Action**

#### **Proposing rulemaking related to regulation of utilities and providing an opportunity for public comment**

The Utilities Commission hereby proposes to adopt new Chapter 28, “Regulation of Municipal and Certain Other Gas Utilities Under Iowa Code Chapter 476,” Iowa Administrative Code.

#### *Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Iowa Code chapter 476.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code sections 476.1B, 476.1C and 476.2.

#### *Purpose and Summary*

Proposed Chapter 28 contains the Commission’s procedure for municipal and certain other gas utilities operating in Iowa. The purpose of the rulemaking is largely to separate provisions related to municipal gas utilities from the current 199—Chapter 19 into the new Chapter 28. Existing 199—Chapter 19 includes rules for both rate-regulated gas utilities and municipal gas utilities. The Commission has previously separated the rules for rate-regulated and municipal electric facilities, so this rulemaking continues that regulatory attempt to streamline rules for both utility types. These changes also allow the Commission to promote conformity between 199—Chapters 19, 27, and 28.

The Commission issued an order commencing rulemaking on April 16, 2026. The order is available on the Commission’s electronic filing system, [efs.iowa.gov](https://efs.iowa.gov), under Docket No. RMU-2025-0028.

*Regulatory Analysis*

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on January 7, 2026. A public hearing was held on the following date(s):

- February 12, 2026

The hearing was attended by the Office of Consumer Advocate, a division of the Iowa Department of Justice; Iowa Association of Electric Cooperatives (IAEC); Black Hills/Iowa Gas Utility Company, LLC d/b/a Black Hills Energy (Black Hills); MidAmerican Energy Company (MidAmerican); and Interstate Power and Light Company. Based on the written and oral comments received, the Commission modified proposed Chapter 28 to produce the version in this Notice of Intended Action.

*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*

No waiver provision is included in the proposed amendments because the Commission has a general waiver provision in rule 199—1.3(17A,474,476) that provides procedures for requesting a waiver.

*Public Comment*

Any interested person may submit written or oral comments concerning this proposed rulemaking, which must be received by the Commission no later than 4:30 p.m. on June 16, 2026. Comments should be directed to:

IT Support  
Iowa Utilities Commission  
Phone: 515.725.7300  
Email: [ITSupport@iuc.iowa.gov](mailto:ITSupport@iuc.iowa.gov)

*Public Hearing*

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

|               |                         |
|---------------|-------------------------|
| June 18, 2026 | Commission Hearing Room |
| 9 to 11 a.m.  | 1375 East Court Avenue  |
|               | Des Moines, Iowa        |
|               | Also via Zoom           |

Persons who wish to make oral comments at the 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 the 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. Adopt the following **new** 199—Chapter 28:

CHAPTER 28  
REGULATION OF MUNICIPAL AND CERTAIN OTHER GAS UTILITIES  
UNDER IOWA CODE CHAPTER 476

**199—28.1(476) General information.** Iowa Code section 476.2(1) provides that the Iowa utilities commission shall have authority to establish all needful, just, and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, content and filing of reports, documents and other papers provided for in Iowa Code chapter 476 or in the commission's rules.

**28.1(1) Application of rules.** The rules shall apply to gas utilities operating within the state of Iowa subject to Iowa Code sections 476.1B and 476.1C, and to the construction, operation, and maintenance of pipelines to the extent provided in Iowa Code chapter 479, and supersede all tariffs on file with the commission that are in conflict with these rules.

**28.1(2) Regulation of gas utilities.** Iowa Code sections 476.1B and 476.1C provide that certain gas utilities are not subject to regulation of the commission, except for regulatory action pertaining to the following:

- a. Assessment of fees for the support of the commission and the office of consumer advocate pursuant to Iowa Code section 476.10.
- b. Safety standards and engineering standards.
- c. Iowa Code sections 476.20, 476.21, and 476.51.

**28.1(3) Definitions.** The following words and terms, when used in these rules, have the meanings indicated below:

*"Appliance"* means any device that utilizes gas fuel to produce light, heat, or power.

*"CFR"* means the Code of Federal Regulations in effect as of [the effective date of this rulemaking] unless a separate effective date is identified in a specific rule.

*"Complaint"* as used in these rules is a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility failure to fulfill an obligation.

*"Cubic foot"* of gas means:

1. Where gas is supplied and metered to customers at the pressure (as defined in subrule 28.7(2)) normally used for domestic customers' appliances, a cubic foot of gas shall be that quantity of gas that, at the temperature and pressure existing in the meter, occupies one cubic foot, except that where a temperature compensated meter is used, the temperature base shall be 60 degrees Fahrenheit.

2. When gas is supplied to customers at other than the pressure in numbered paragraph "1," the utility shall specify in its rules the base for measurement of a cubic foot of gas. Unless otherwise stated by the utility, such cubic foot of gas shall be that quantity of gas that, at a temperature of 60 degrees Fahrenheit and a pressure of 14.73 pounds per square inch absolute, occupies one cubic foot.

3. The standard cubic foot of gas for testing the gas itself for heating value shall be that quantity of gas, saturated with water vapor, that, at a temperature of 60 degrees Fahrenheit and a pressure of 30 inches of mercury, occupies one cubic foot. (Temperature of mercury = 32 degrees Fahrenheit acceleration due to gravity = 32.17 ft. per second per second density = 13.595 grams per cubic centimeter.)

*"Customer"* means any person, firm, association, or corporation; any agency of the federal, state, or local government; or any legal entity responsible by law for payment for the gas service or heat from the gas utility.

*"Delinquent"* or *"delinquency"* means an account for which a service bill or service payment agreement bill has not been paid in full on or before the last day for timely payment.

*"Gas,"* unless otherwise specifically designated, means manufactured gas, natural gas, other hydrocarbon gases, or any mixture of gases produced, transmitted, distributed, or furnished by any gas utility.

*“Gas plant”* means all facilities including all real estate, fixtures, and property owned, controlled, operated, or managed by a gas utility for the production, storage, transmission or distribution of gas and heat.

*“Interruption of service”* means any disturbance of the gas supply whereby gas service to a customer cannot be maintained.

*“Main”* means a gas pipe, excluding a service line, that is owned, operated, or maintained by a utility and is used for the purpose of distribution of gas.

*“Meter,”* without other qualification, means any device or instrument used by a utility in measuring a quantity of gas.

*“Meter shop”* means a shop where meters are inspected, repaired, and tested and may be at a fixed location or may be mobile.

*“Pressure,”* unless otherwise stated, is expressed in pounds per square inch above atmospheric pressure, i.e., gauge pressure.

*“Rates”* means the same as defined in Iowa Code section 384.80 and includes all charges or fees imposed or collected for the provision of, or incidental to, utility service.

*“Service line”* means a distribution line that transports gas from a common source of supply to a customer meter or the connection to a customer’s piping, whichever is farther downstream, or the connection to a customer’s piping if there is not a customer meter. A “customer meter” is the meter that measures the transfer of gas from a utility to a customer.

*“Timely payment”* means a payment on a customer’s account made on or before the date shown on a current bill for service, or on a form that records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date that determines application of a late payment charge.

*“Town border station”* means the delivery point or measuring station at which a gas distribution utility receives gas from a natural gas transmission company.

*“Utility”* means any person; partnership; business association; or corporation, domestic or foreign, owning or operating any facilities for furnishing gas or heat to the public for compensation.

**28.1(4)** *Gas utilities service rules.* Gas utilities service rules or other legally enforceable provisions are to be consistent with the provisions in this chapter and must be available to all customers.

#### **199—28.2(476) Maps; records.**

**28.2(1)** Each gas utility is to maintain current maps, plans, and records of its entire gas systems, with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving customers in its service area. A utility shall maintain a correct set of utility system maps for each operating or distribution area, and such maps are to be made available to commission personnel upon request. The maps shall show:

- a. Peak shaving facility location(s).
- b. Feeder and distribution mains indicating size and pressure.
- c. System metering (town border stations and other supply points).
- d. Regulator stations in system indicating inlet and outlet pressures.
- e. Calorimeter location.
- f. State boundary crossing.
- g. Franchise area.
- h. Names of all communities (post offices) served.

**28.2(2)** Reports to federal agencies. Copies of reports submitted to the U.S. Department of Transportation pursuant to 49 CFR Part 191, 192, 193, or 199 shall be filed with the commission no later than ten days following the submission. Utilities operating in other states shall provide data to the commission for Iowa only.

#### **199—28.3(476) Customer relations.**

**28.3(1)** *Notification to customers by bill insert.* At least annually, each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a

utility representative qualified to assist in resolving the complaint can be reached and include the following statement: "If your complaint is related to service disconnection, payment agreements, safety, or renewable energy, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Commission by calling 515.725.7300, or toll-free 877.565.4450, by writing to 1375 E. Court Ave., Des Moines, IA 50319-0069; or by email to [customer@iuc.iowa.gov](mailto:customer@iuc.iowa.gov)." The utility may use different language with commission approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information required in this subrule.

**28.3(2) *Payment agreements.***

*a. Availability of a first payment agreement.* When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the utility for residential utility service and is not in default of a payment agreement with the utility, the utility shall offer the customer an opportunity to enter into a reasonable payment agreement. The offer of a payment agreement is to be made prior to disconnection. The utility is not required to offer a customer who has been disconnected from service a payment agreement consistent with these rules unless the utility did not comply with these rules prior to disconnection.

*b. Reasonableness.* Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, size of the bill, amount of time and reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of health and human services or another agency.

*c. Terms of payment agreements.*

(1) First payment agreement. The following conditions are to be offered to customers who have received a disconnection notice and are not in default of a payment agreement:

1. For customers who received a disconnection notice in conformance with these rules, an agreement with at least 12 even monthly payments is to be offered. A customer may pay off the delinquency early without incurring any prepayment penalties. A customer will not be charged interest, or a late payment charge, on a payment agreement where the customer is making payments consistent with the terms of the payment agreement, and the customer will not be required to pay a portion of the delinquent amount to enter into a payment agreement.

2. A provision for payment of the current amount owed by the customer is to be offered.

3. The utility may require the customer to enter into a budget billing plan to pay the current bill.

4. When the customer makes the agreement in person, a signed copy of the agreement is to be provided to the customer.

5. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission.

6. When a payment agreement is made over the telephone or through electronic transmission, a written agreement reflecting the terms and conditions of the agreement is to be provided to the customer within three days of the date the oral or electronic agreement is entered into.

7. The document will be considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage paid. If delivery is by other than U.S. mail, the document will be considered provided to the customer when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing.

8. The payment agreement is deemed accepted by the customer unless the customer notifies the utility otherwise within ten days from the date the document is provided. The address and toll-free telephone number where a qualified representative can be reached is to be included in the payment agreement.

9. Once the first payment required by the agreement is made by the customer or on behalf of the customer, the oral or electronic agreement is deemed accepted by the customer.

10. Each customer entering into a first payment agreement is allowed at least one late payment that is four days or less beyond the due date for payment, and the first payment agreement remains in effect.

11. The initial payment is due on the due date for the next regular bill.

(2) Second payment agreement. A second payment agreement is to be offered to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement.

1. The second payment agreement will be for a term at least as long as the term of the first payment agreement.

2. The customer is to pay for current service in addition to the monthly payments.

3. The customer may be required to make the first payment up front as a condition of entering into the second payment agreement.

4. The utility may also require the customer to enter into a budget billing plan to pay the current bill.

(3) Additional payment agreements. The utility may offer additional payment agreements to the customer.

*d. Refusal by utility.* A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally but will provide a written refusal to the customer, stating the reason for the refusal, within three days of the oral notification. The written refusal is considered provided to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal is considered provided to the customer when handed to the customer or when delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing.

*e. Customer request for assistance.* A customer may ask the commission for assistance in working out a reasonable payment agreement. The request for assistance is to be made to the commission within ten days after the written refusal is provided, and disconnection will not take place during the commission's review.

**28.3(3) Bill payment terms.** The bill is to be considered provided to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill is to be considered provided when delivered to the last-known address of the customer, or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing. An account shall not be delinquent until 20 days have passed since the bill was provided to the customer. For customers on more frequent billing intervals, an account shall not be delinquent until five days have passed since the bill was provided to the customer. A late payment charge cannot be assessed if payment is received within 20 days of the date the bill is provided.

*a.* The date of delinquency for all residential customers or other customers whose consumption is less than 250 ccf per month is changeable for cause, such as but not limited to 15 days from the approximate date each month upon which income is received by the person responsible for payment. Thirty days beyond the date of previous bill preparation is the maximum delay allowed.

*b.* In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge is limited to 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge.

*c.* If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment is to be credited pro rata between the bill for utility services and related taxes.

*d.* Each account is allowed not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules are to include on one monthly bill in each period of eligibility that the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The utility's rules are to state how the customer is notified that the eligibility has

been used. Complete forgiveness has no effect upon the credit rating of the customer or collection of late payment charges.

**28.3(4) *Meter testing standards.*** Gas utilities are to establish written meter testing standards and procedures for customers who have complaints about the accuracy of the customer's meters. Gas utilities that utilize a third-party vendor/contractor to conduct meter testing shall ensure, at a minimum, that the meter testing standards used by the third-party vendor/contractor address the subject areas listed in subrule 28.3(5). The meter testing standards are to be made available to a customer upon request. The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

- a.* American National Standard for Gas Displacement Meters (500 Cubic Feet Per Hour Capacity and Under), ANSI B109.1, published April 15, 2019, reaffirmed April 16, 2024.
- b.* American National Standard for Diaphragm Type Gas Displacement Meters (Over 500 Cubic Feet Per Hour Capacity), ANSI B109.2, published March 16, 2020, reaffirmed July 3, 2025.
- c.* American National Standard for Rotary Type Gas Displacement Meters, ANSI B109.3, published February 5, 2019, reaffirmed April 16, 2024.
- d.* Measurement of Gas Flow by Turbine Meters, ANSI/ASME MFC-4M-1986, reaffirmed 2025.
- e.* Orifice Metering of Natural Gas and Other Related Hydrocarbon Fluids, API MPMS Chapter 14.3, Part 1 (R2017), Part 2 (R2024), Part 3 (R2021), and Part 4 (R2026).

**28.3(5) *Meter testing procedures.*** The meter testing standards and procedures shall, at a minimum, address the following subject areas:

- a.* Classification of meters by capacity, type, and any other factor considered pertinent.
- b.* Checking of new meters for acceptable accuracy before they are placed in service.
- c.* Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments, or repairs and including meters removed from service for any reason.
- d.* Periodic calibration or testing of devices or instruments used by the utility to test meters.
- e.* Leak testing of meters before return to service.
- f.* The limits of meter accuracy considered acceptable by the utility.
- g.* The nature of meter and meter test records maintained by the utility.

**28.3(6) *Meter adjustment.*** All meters and associated metering devices, when tested, will be adjusted as closely as practicable to the condition of zero error.

**28.3(7) *Request tests.*** Utilities will test a customer's meter at the customer's request but need not do so more frequently than once in 18 months. Test results will be mailed to the customer within ten days of the completed test, and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted. If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer \$25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

**28.3(8) *Referee tests.*** Upon written request by a customer or utility, the commission will conduct a referee test of a meter but not more frequently than once in 18 months. In addition to the written request, the customer will also provide the utility with a \$30 deposit. The customer's request to the commission will indicate that the deposit has been paid. Within five days of receipt of the written request and payment, the commission will notify the utility of the test. The utility shall, within 30 days after notification of the request, schedule the date, time, and place of the test with the commission and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments made. The commission will issue its report after the test is conducted.

**28.3(9) *Condition of meter.*** No meter that is known to be mechanically defective, has an incorrect correction factor, or has not been tested and adjusted, if necessary, in accordance with paragraphs 28.3(5) "b," "c," and "e," shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the gas requirements of the customer.



**199—28.4(476) Disconnection of service.**

**28.4(1)** *Disconnection procedures and notice.* Utilities may only disconnect service to customers in compliance with the following procedure and requirements:

*a.* Service may be disconnected without notice:

- (1) In the event of a condition on the customer's premises determined by the utility to be hazardous.
- (2) In the event of customer use of equipment in a manner that adversely affects the utility's equipment or the utility's service to others.
- (3) In the event of tampering with the equipment furnished and owned by the utility. A broken or absent meter seal alone does not constitute tampering.

(4) In the event of unauthorized use.

*b.* The utility shall give written notice of pending disconnection, except as specified in paragraph 28.4(1) "a." The notice will include the reason for the notice and the final date by which the account is to be settled or specific action taken. The notice is to be addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice is to be delivered to the last-known address of the customer or sent via electronic delivery with customer consent. Such consent shall be deemed given when the customer consents to or requests electronic billing. The date for disconnection of service is not to be less than 12 days after the notice is provided. The date for disconnection of service for customers on shorter billing intervals is not to be less than 24 hours after the notice is posted at the service premises.

*c.* Where more than one cause of disconnection exists, one written notice is to be given that includes all reasons for the notice. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes run concurrently.

*d.* Service may be disconnected after proper notice:

- (1) For violation of or noncompliance with the utility's rules.
- (2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way that are specified to be furnished, in the utility's rules filed with the commission, as conditions of obtaining service; for the withdrawal of that same equipment; for the termination of those same permissions or rights; or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the commission.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

*e.* Service may be disconnected after proper notice for nonpayment of a bill or deposit, provided that the utility has complied with the following provisions:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal.

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities set out in subrule 28.4(2). Customers billed more frequently than monthly are to be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each utility representative provides the representative's name and has immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) When disconnecting service to a residence, a diligent attempt is to be made to contact, by telephone or in person, the customer to inform the customer of the pending disconnection and the customer's rights and responsibilities. Between November 1 and April 1, if the attempt at customer contact fails, the premises are to be posted, at least one day prior to disconnection, with a notice informing the customer of the pending disconnection and a copy of the rights and responsibilities available to avoid disconnection.

1. If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the utility is to make a diligent attempt to contact the landlord of the rental unit, if known,

to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord is to be informed of the date when service may be disconnected. The utility will make a diligent attempt to inform the landlord at least 48 hours prior to disconnection of service to a tenant.

2. If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection are to be posted at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

3. If the customer has received notice of disconnection and has a dispute concerning a bill for gas service, the gas utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. Disconnection for nonpayment of the disputed bill is delayed for up to 45 days after the providing of the bill if the customer pays the undisputed amount. The 45 days may be extended by up to 60 days if requested of the utility by the commission in the event the customer files a written complaint with the commission in compliance with 199—Chapter 6.

*f.* Disconnection and reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts are to be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts are to be made to reconnect the customer not later than 11 a.m. the next day.

*g.* Severe cold weather. A disconnection is not to take place where gas is used as the only source of space heating or to control or operate the only space heating equipment at a residence when the actual temperature or the 24-hour forecast of the National Weather Service for the residence's area is predicted to be 20 degrees Fahrenheit or colder. If the utility has properly posted a disconnect notice but is precluded from disconnecting service because of severe cold weather, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the residence's area rises above 20 degrees Fahrenheit and is forecasted to remain above 20 degrees Fahrenheit for at least 24 hours unless the customer has paid in full the past due amount or is otherwise entitled to postponement of disconnection.

*h.* Medical stay. Disconnection of a residential customer will be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises.

(1) An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances that indicate a severe or hazardous health situation.

(2) The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

(3) Verification will postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service is to be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection.

*i.* Winter energy assistance. If between November 1 through April 1 the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, service is not

to be disconnected for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection of service is not allowed from November 1 through April 1 for a resident who is a head of household and who has been certified to the utility by the community action agency as eligible for either the low-income home energy assistance program or the weatherization assistance program.

*j.* Deployment. If the utility is informed that one of the heads of household, as defined in Iowa Code section 476.20, is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

*k.* Abnormal gas consumption. A customer who is subject to disconnection for nonpayment of bill, and who has gas consumption that appears to the customer to be abnormally high, may request the utility provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. Assistance will be provided by the utility by discussing patterns of gas usage that may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance available to the customer.

*l.* A utility may disconnect gas service after 24-hour notice (and without the written 12-day notice) for failure of the customer to comply with the terms of a payment agreement.

*m.* Prior to November 1, a notice describing the availability of winter energy assistance funds and the application process is to be mailed to customers. The notice is to be of a type size that is easily legible and conspicuous and contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. A serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

**28.4(2)** *Notice of customer rights and responsibilities.* The standard form of the summary of the rights and responsibilities to be provided to customers is set out below and will be provided by a utility with all disconnection notices. A nonstandard rights and responsibilities notice may be used with commission approval. The standard customer rights and responsibilities notice is as follows:

**CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF GAS SERVICE  
FOR NONPAYMENT**

**1. What can I do if I receive a notice from the utility that says my service will be shut off because I have a past due bill?**

- a. Pay the bill in full;
- b. Enter into a reasonable payment plan with the utility (see #2 below);
- c. Apply for and become eligible for low-income energy assistance (see #3 below);
- d. Give the utility a written statement from a doctor or public health official stating that shutting off your gas service would pose an especial health danger for a person living at the residence (see #4 below); or
- e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

**2. How do I go about making a reasonable payment plan? (Residential customers only)**

- a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, you are to be offered a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.
- b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.
- c. If you do not make the payments you promise, the utility may shut off your gas service on one day's notice, unless all the money you owe the utility is paid or you enter into another payment agreement.

**3. How do I apply for low-income energy assistance? (Residential customers only)**

- a. Applications are taken at your local community action agency. If you are unsure where to apply, call 211 or 800.244.7431, or visit [hhs.iowa.gov/programs/programs-and-services/liheap](https://hhs.iowa.gov/programs/programs-and-services/liheap). To prevent disconnection, contact the utility prior to disconnection of your service.

b. To avoid disconnection, you must apply for energy assistance or weatherization before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

c. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1. Between November 1 and April 1, the utility will delay disconnection of your service for 30 days once you notify the utility that you are applying for energy assistance or weatherization assistance, to allow you time to obtain assistance. Only one 30-day delay is required during the moratorium period.

**4. What if someone living at the residence has a serious health condition? (Residential customers only)**

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your gas service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility's office within five days of when your doctor or public health official notifies the utility of the health condition; otherwise, your gas service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

**5. What should I do if I believe my bill is not correct?**

You may dispute your bill by telling the utility that you dispute the bill and paying the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Commission for assistance in resolving the dispute (see #9 below).

**6. When can the utility shut off my gas service because I have not paid my bill?**

- a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m. Monday through Friday.
- b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.
- c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).
- d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.
- e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

g. If one of the heads of household is a service member deployed for military service, gas service cannot be shut off during the deployment or within 90 days after the end of deployment. In order for this exception to disconnection to apply, the utility will need to be informed of the deployment prior to disconnection. However, you will still owe the utility for service used during this time.

**7. How will I be told the utility is going to shut off my service?**

- a. You must be given a written notice at least 12 days before the gas service can be shut off for nonpayment. This notice will include the reason for shutting off your service.
- b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.
- c. The utility must try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door of or another conspicuous place at your residence to tell you that your gas service will be shut off.

**8. If service is shut off, when will it be turned back on?**

a. The utility will turn your service back on if you pay the whole amount you owe. The service shall be restored for 30 days if you provide the utility with a medical verification from a doctor or public health official of an especial danger to health within 14 days of a shutoff for nonpayment.

b. If you make your payment during regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility is to do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. That fee may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

**9. Is there any other help available besides my utility?**

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Commission toll-free at 877.565.4450. You may also write the Iowa Utilities Commission at 1375 E. Court Ave., Des Moines, IA 50319-0069, or email [customer@iuc.iowa.gov](mailto:customer@iuc.iowa.gov). Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid and may contact Iowa Legal Aid at 800.532.1275.

**28.4(3)** *When disconnection is not allowed.*

a. No disconnection may take place from November 1 through April 1 for a resident who has been certified to the utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

b. If the utility is informed that one of the heads of household, as defined in Iowa Code section 476.20, is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

**28.4(4)** *Servicing of utilization control equipment.* Each utility is to service and maintain any equipment it uses on a customer's premises and correctly set and keep in proper adjustment any utility-owned thermostats, clocks, relays, time switches, or other devices that control the customer's service in accordance with the provisions in the utility's schedules.

**28.4(5)** *Customer complaints.* A utility will promptly and thoroughly investigate all complaints concerning its practices, facilities, or services. The utility is to keep such records of customer complaints as will enable it to review and analyze its procedures and actions.

a. Each utility is to develop a fully informative procedure for the resolution of customer complaints.

b. The utility is to take reasonable steps to ensure that customers unable to travel are not denied the right to be heard.

c. The final step in a complaint review procedure, if the utility and customer are not able to agree on a resolution of the complaint, is a filing for commission resolution of the issues if the commission determines it has jurisdiction.

**199—28.5(476) Engineering standards.**

**28.5(1)** *Requirement for good engineering practice.* The gas plant of the gas utility shall be constructed, installed, maintained, and operated in accordance with accepted good engineering practice in the gas industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

**28.5(2)** *Standards incorporated by reference.*

a. The design, construction, operation, and maintenance of gas systems and liquefied natural gas facilities shall be in accordance with the following standards where applicable:

(1) Transportation of Natural and Other Gas by Pipeline; Annual, Incident, and Other Reporting, 49 CFR Part 191.

(2) Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards, 49 CFR Part 192.

(3) Liquefied Natural Gas Facilities: Federal Safety Standards, 49 CFR Part 193.

- (4) Drug and Alcohol Testing, 49 CFR Part 199.
- (5) Gas Transmission and Distribution Piping Systems, ASME B31.8 as incorporated by reference in 49 CFR 192.7.
- (6) Utility LP-Gas Plant Code, NFPA 59 as incorporated by reference in 49 CFR 192.7.
- (7) At railroad crossings, the engineering standards for pipelines rule found in 199—Chapter 42.
- b. The following publications are adopted as standards of accepted good practice for gas utilities:
  - (1) National Fuel Gas Code, NFPA 54/ANSI Z223.1, published August 25, 2023.
  - (2) Standard for Fire Safety Criteria for Manufactured Home Installations, Sites, and Communities, NFPA 501A, published 2025.

**28.5(3) *Adequacy of gas supply.*** The natural gas regularly available from supply sources supplemented by production or storage capacity must be sufficiently large to meet all reasonable demands for firm gas service.

**28.5(4) *Gas transmission and distribution facilities.*** The utility's gas transmission and distribution facilities shall be designed, constructed, and maintained as required to reliably perform the gas delivery burden placed upon them. Utilities will be capable of emergency repair work on a scale consistent with its scope of operation and with the physical conditions of its transmission and distribution facilities.

In appraising the reliability of the utility's transmission and distribution system, the commission will consider, as principal factors, the condition of the physical property and the size, training, supervision, availability, equipment, and mobility of the maintenance forces.

**28.5(5) *Inspection of gas plant.*** A utility will adopt and follow a program of inspection of its gas plant in order to determine the necessity for replacement and repair. The frequency of the various inspections is to be based on the utility's experience and accepted good practice. Utilities will keep sufficient records to give evidence of compliance with its inspection program.

#### **199—28.6(476) Safety.**

**28.6(1) *Compliance.*** Each utility shall comply with commission rules for standards for safety and operating reliability under this subrule.

**28.6(2) *Protective measures.*** Each utility shall exercise reasonable care to reduce hazards inherent in connection with its gas service and to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public and fitted to the size and type of its operations. Utilities will maintain a summary of all reportable failures arising from its operations.

**28.6(3) *Failure investigation and prevention.*** Utilities are to give reasonable assistance to the commission in the investigation of the cause of failures and in the determination of suitable means of preventing failures.

**28.6(4) *Reportable incidents.*** Utilities are to maintain a summary of all reportable incidents arising from operations that require notification pursuant to subrule 28.10(1).

**28.6(5) *Gas leaks.*** A report of a gas leak shall be considered an emergency requiring immediate attention.

**28.6(6) *Turning on gas.*** Each utility upon the installation of a meter and turning on gas or the act of turning on gas alone shall take the necessary steps to assure itself that there exists no flow of gas through the meter, which is a warning that the customer's piping or appliances are not safe for gas turn on.

**28.6(7) *Odorization.*** Any gas distributed to customers through gas mains or gas services or used for domestic purposes in compressor plants, which does not naturally possess a distinctive odor to the extent that its presence in the atmosphere is readily detectable at all gas concentrations of one-fifth of the lower explosive limit and above, shall have an odorant added to it to make it so detectable. Odorization is not necessary, however, for such gas as is delivered for further processing or use where the odorant would serve no useful purpose as a warning agent. Utilities will test the gas to ensure the odor meets the standards of subrule 28.5(2). Prompt remedial action shall be taken if odorization levels do not meet the prescribed limits for detectability.

**28.6(8) *Compliance.*** All compliance issues identified during a commission inspection are to be corrected by the utility within 12 months of the notification. If such corrective actions cannot be taken

within that time frame, the utility shall notify the commission and provide an explanation as to why such actions will take longer and the additional steps, if any, the utility is undertaking to maintain public health and safety in the meantime.

**28.6(9) *Utility personnel.*** Each utility is to inform the commission if a personnel change in gas foreman, supervisor, superintendent or manager occurs. This notice will occur no later than 30 days from the date of personnel change.

**199—28.7(476) Standards of quality of service.**

**28.7(1) *Purity.*** All gas supplied to customers shall be substantially free of impurities that may cause corrosion of mains or piping or from corrosive or harmful fumes when burned in a properly designed and adjusted burner. If the municipality or certain other gas utility receives gas from a source other than an interstate transmission pipeline, or a pipeline that is subject to gas quality specifications defined by a tariff, the municipality or certain other gas utility must take additional steps to ensure gas purity in the gas system.

**28.7(2) *Pressure limits.*** The maximum allowable operating pressure for a low-pressure distribution system shall not be so high as to cause the unsafe operation of any connected and properly adjusted low-pressure gas-burning equipment.

**28.7(3) *Adequacy for pressure.*** Each utility shall have a substantially accurate knowledge of the pressures inside its piping. Periodic pressure measurements shall be taken during periods of high demand at remote locations in distribution systems to determine the adequacy of service. Records of such measurements including the date, time, and location of the measurement shall be maintained not less than two years.

**28.7(4) *Standards for pressure measurements.***

*a. Secondary standards.* Each utility shall own or have access to a dead weight tester that is maintained in an accurate condition.

*b. Working standards.* Each utility must have or have access to manometers, laboratory quality indicating pressure gauges, and field-type dead weight pressure gauges as necessary for the proper testing of the indicating and recording pressure gauges used in determining the pressure on the utility's system. Working standards are to be checked periodically by comparison with a secondary standard or by calibration of the working standard by a third-party vendor/contractor or by the manufacturer.

**28.7(5) *Handling of standards.*** Extreme care must be exercised in the handling of standards to ensure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

**28.7(6) *Heating value.***

*a. Awareness.* Each utility shall have a substantially accurate knowledge of the heating value of the gas being delivered to customers at all times.

*b. Natural and LP gas.* The heating value of natural gas and undiluted, commercially pure LP gas is not considered to be under the control of the utility. Utilities will determine the allowable range of monthly average heating values within which its customers' appliances may be expected to function properly without repeated readjustment of the burners.

*c. Renewable natural gas (RNG).* The heating value of gas supplied from an RNG facility is considered within the control of the RNG supplier. The average daily heating value of mixed gas in a distribution system shall be at least 95 percent of that normally delivered by the pipeline supplier. RNG producers are responsible for ensuring the gas produced from the RNG facility is compatible to meet these heating requirements.

*d. Peak shaving or other mixed gas.* The heating value of gas in a distribution system that includes gas from LP or LNG peak shaving facilities, or gas from a source other than a pipeline supplier, is considered within the control of the utility. The average daily heating value of mixed gas shall be at least 95 percent of that normally delivered by the pipeline supplier. All mixed gas shall have a specific gravity of less than 1.000, and heating value shall not be so high as to cause improper operation of properly adjusted customer equipment.

*e. Heating value determination and records.* Unless acceptable heating value information is available for all periods from other sources, including the pipeline supplier, utilities will have a method by which the heating value of the gas in a distribution system can be accurately determined. The type, accuracy, operation, and location of equipment, and the accuracy of computation methods, shall be in accordance with accepted industry practices and equipment manufacturer's recommendations, subject to review by the commission.

**199—28.8(476) Customer contribution fund.**

**28.8(1)** *Applicability and purpose.* This rule applies to each gas utility as defined in Iowa Code sections 476.1B and 476.1C. Pursuant to Iowa Code section 476.66, each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home assistance energy program for payment of winter heating bills.

**28.8(2)** *Notification.* Notice of the customer contribution fund is to be given to all customers at least twice a year. Upon commencement of service and at least once a year, the notice is to be mailed or personally delivered to all customers or provided by electronic means to those customers who have consented to receiving electronic notices. The other notice may be published in a local newspaper(s) of general circulation within the service territory of the utility. A utility serving fewer than 6,000 customers may publish its semiannual notices locally in a free newspaper, utility newsletter, or shopper's guide instead of a newspaper. At a minimum, the notice is to include:

*a.* A description of the availability and the purpose of the fund.

*b.* A customer authorization form that includes a monthly billing option and methods of contribution.

**28.8(3)** *Methods of contribution.* Contribution methods may include monthly pledges, as well as one-time or periodic contributions. A pledge by a customer or other party is not a binding contract between the utility and the pledger. Delayed contributions are not subject to late payment charges. Each utility may allow persons or organizations to contribute matching funds.

**28.8(4)** *Annual report.* On or before September 30 of each year, each utility is to file with the commission a report of all the customer contribution fund activity for the previous fiscal year from July 1 through June 30 on a form provided by the commission that contains an accounting of the total revenues collected and all distributions of the fund.

**199—28.9(476) Notification of outages.**

**28.9(1)** *Notification.* The notification requirements in this rule are for the timely collection of gas outage information that may be useful to emergency management agencies in providing for the safety and welfare of individual Iowa citizens. Each utility shall notify the commission when it is projected that an outage may result in a loss of service for more than six hours and the outage meets one of the following criteria:

*a.* Loss of service for more than six hours to substantially all of a municipality or certain other gas utility's customers, including the surrounding area served by the same utility. A utility may use loss of service within the utility's service territory to 75 percent or more of customers within a municipality or of a certain other gas utility, including the surrounding area served by the utility, to meet this criterion; or

*b.* Any other outage considered significant by the utility. This includes loss of service for more than six hours to significant public health and safety facilities known to the utility at the time of the notification.

**28.9(2)** *Information about outages.*

*a.* Notification shall be provided regarding outages that meet the requirements of subrule 28.9(1) to the commission duty officer by email at [dutyofficer@iuc.iowa.gov](mailto:dutyofficer@iuc.iowa.gov) or, in appropriate circumstances, by telephone at 515.745.2332. Notification shall be made at the earliest possible time after it is determined the event may be reportable and should include the following information, as available:

- (1) The general nature or cause of the outage;
- (2) The area affected;



(3) The approximate number of customers that have experienced a loss of gas service as a result of the outage;

(4) The time when service is estimated to be restored; and

(5) The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the outage. The notice should be supplemented as more complete or accurate information is available.

b. The utility is to provide to the commission updates of the estimated time when service will be restored to all customers able to receive service or of significantly changed circumstances unless service is restored within one hour of the time initially estimated.

c. The utility is to notify the commission once service is fully restored to all customers after an outage meeting the requirements of subrule 28.9(1).

**28.9(3) *Planned interruptions.*** Planned interruptions by utilities are to be made at a time that will not cause an unreasonable inconvenience to customers. Adequate notice should be provided to customers that will be affected when a planned interruption lasts longer than one hour.

**28.9(4) *Other interruptions.*** Each utility shall make reasonable efforts to avoid interruptions of service, but when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety. Records will be maintained for not less than two years of interruptions of service reported pursuant to subrule 28.9(2). Utilities will periodically review these records to determine steps to be taken to prevent recurrence.

#### **199—28.10(476) Incident notification and reports.**

**28.10(1) *Notification.*** Utilities will notify the commission immediately, or as soon as practical, of any incident involving the release of gas, failure of equipment, or interruption of facility operations that results in any of the following:

- a. A death or personal injury necessitating in-patient hospitalization.
- b. Estimated property damage of \$50,000 or more to the property of the utility and to others, including the cost of gas lost.
- c. Unintentional estimated gas loss of three million cubic feet or more.
- d. Emergency shutdown of a liquefied natural gas (LNG) facility.
- e. An unplanned interruption of service to 50 or more customers.
- f. Evacuation of 50 or more people.
- g. Evacuation of a school, hospital, or health care facility.
- h. Rerouting of traffic or closing of a federal or state highway by public emergency responders.
- i. Traditional news media attention.
- j. Unintentional fire or explosion.
- k. The release of gas due to excavation damage.
- l. Any other incident considered significant by the utility.

**28.10(2) *Reporting information.*** The utility shall notify the commission by email, as soon as practical, of any reportable incident at [dutyofficer@iuc.iowa.gov](mailto:dutyofficer@iuc.iowa.gov) or, when email is not available, by calling the commission duty officer at 515.745.2332. The person sending the email or the caller shall leave a call-back number for a person who can provide the following information:

- a. The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.
- b. The location of the incident.
- c. The time of the incident.
- d. The number of deaths or personal injuries and the extent of those injuries, if any.
- e. An initial estimate of damages.
- f. The number of services interrupted.
- g. A summary of the significant information available to the utility regarding the probable cause of the incident and extent of damages.
- h. Any oral or written report required by the U.S. Department of Transportation and the name of the person who made the oral report or prepared the written report and when such a report was made.

**28.10(3)** *Written incident reports.* Within 30 days of the date of the incident, the utility shall file a written report with the commission that includes the information listed in subrule 28.10(2), the probable cause as determined by the utility, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available at a later date, the utility will timely file the information in a supplemental report. The utility will also provide the commission with copies of any written reports concerning an incident or safety-related condition filed with or submitted to the U.S. Department of Transportation or the National Transportation Safety Board.

**199—28.11(476) Quarterly reporting.**

**28.11(1)** *Excavation damage with loss of gas.* Utilities shall submit a quarterly report to the commission with information related to any excavation damages that resulted in a release of gas during the reporting period. This report must include the following information for each instance of excavation damage:

- a. Date of the damage.
- b. Address of the damage.
- c. Type of line damaged (service, main, or transmission).
- d. Name of the excavation companies involved.
- e. Name of the excavation equipment involved.
- f. One Call ticket number, if applicable.
- g. Any such other information as may be deemed pertinent on forms prescribed by the commission, which are located on the commission's website.

**28.11(2)** *One Call ticket volume.* Each quarter, utilities must report to the commission the total number of One Call tickets received during the reporting period.

**28.11(3)** *Reporting period.* Each quarterly report is due the fifteenth of the month following the end of the quarter.

- a. The first-quarter reporting period covers January 1 to March 31, with the quarterly report due on April 15.
- b. The second-quarter reporting period covers April 1 to June 30, with the quarterly report due on July 15.
- c. The third-quarter reporting period covers July 1 to September 30, with the quarterly report due on October 15.
- d. The fourth-quarter reporting period covers October 1 to December 31, with the quarterly report due on January 15 of the following year.

These rules are intended to implement Iowa Code chapter 476 and sections 476.20, 476.21, 476.51, 476.66, 476.1B, and 476.1C.

**ARC 0298D**

**WORKFORCE DEVELOPMENT DEPARTMENT[871]**

**Notice of Intended Action**

**Proposing rulemaking related to contested cases  
and providing an opportunity for public comment**

The Workforce Development Department hereby proposes to adopt new Chapter 2506, "Contested Cases," Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

*Purpose and Summary*

This proposed rulemaking modifies the Uniform Rules on Agency Procedure related to contested cases (7—Chapter 2506) to ensure that contested cases arising from Workforce Innovation and Opportunity Act programs, Registered Apprenticeship programs, and Vocational Rehabilitation programs are governed by the applicable federal regulations (20 CFR Part 683, Subpart F; 29 CFR Parts 29 and 30; and 34 CFR Part 361) and not the contested case provisions of 7—Chapter 2506.

The new Uniform Rules on Agency Procedure are effective as of January 13, 2026, which means there is an inconsistency between the contested case provisions of the Uniform Rules on Agency Procedure and the procedures laid out in 20 CFR Part 683, Subpart F; 29 CFR Parts 29 and 30; and 34 CFR Part 361. Earlier adoption of this rulemaking will allow the Department to ensure any contested case coming before the Department has clear direction as to the appropriate procedural requirements.

*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 7—Chapter 2504.

*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 June 16, 2026. Comments should be directed to:

Jeffrey Koncsol  
Iowa Workforce Development  
1000 East Grand Avenue  
Des Moines, Iowa 50319  
Phone: 515.725.5400  
Email: [jeffrey.koncsol@iwd.iowa.gov](mailto:jeffrey.koncsol@iwd.iowa.gov)

*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).

*Emergency Rulemaking Adopted by Reference*

This proposed rulemaking is also published herein as an Adopted and Filed Emergency rulemaking (see **ARC 0299D**, IAB 5/27/26). The purpose of this Notice of Intended Action is to solicit public comment on that emergency rulemaking, whose subject matter is hereby adopted by reference.

**Notice of Electric and Natural Gas Delivery Tax Rate Changes**

Pursuant to the authority of Iowa Code sections 437A.4 and 437A.5, the Director of Revenue hereby gives notice of the changes to the electric and natural gas delivery tax rates. 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, for replacement taxes payable in the 2026-2027 fiscal year.

**2026 ELECTRIC DELIVERY TAX RATES BY SERVICE AREA  
RATE CHANGES ONLY**

| <b>CO. #</b> | <b>MUNICIPAL ELECTRICS</b>          | <b>DELIVERY TAX<br/>RATE</b> |
|--------------|-------------------------------------|------------------------------|
| 3109         | Lenox Municipal Light & Power       | 0.00049715                   |
| 3112         | Manning Municipal Electric          | 0.00009700                   |
| 3201         | Algona Municipal Utilities          | 0.00016676                   |
| 3216         | Buffalo Municipal Electric System   | 0.00000370                   |
| 3217         | Burt Municipal Electric Utility     | 0.00000212                   |
| 3221         | Cedar Falls Municipal Elec. Utility | 0.00019677                   |
| 3228         | Bigelow Municipal Electric Utility  | 0.00296896                   |
| 3230         | City of Fredericksburg              | 0.00000858                   |
| 3237         | Coon Rapids Municipal Utilities     | 0.00002307                   |
| 3258         | Grand Junction Municipal Utilities  | 0.00000475                   |
| 3267         | Hopkinton Municipal Utilities       | 0.00000617                   |
| 3288         | McGregor Municipal Utilities        | 0.00000776                   |
| 3315         | Primghar Municipal Light Plant      | 0.00001478                   |
| 3324         | Spencer Municipal Utilities         | 0.00012152                   |
| 3337         | Villisca Municipal Power Plant      | 0.00025674                   |
| 3338         | Waverly Light & Power               | 0.00078139                   |
| 3345         | West Bend Municipal Power Plant     | 0.00076239                   |
| 3347         | West Point Municipal Utility System | 0.00177594                   |

| <b>CO. #</b> | <b>IOUs — ELECTRICS</b>     | <b>DELIVERY TAX<br/>RATE</b> |
|--------------|-----------------------------|------------------------------|
| 7206         | Amana Society Service Co.   | 0.00075059                   |
| 7289         | MidAmerican Energy          | 0.00224620                   |
| 7305         | Omaha Public Power District | 0.00113781                   |

| <b>CO. #</b> | <b>RECs</b>                    | <b>DELIVERY TAX<br/>RATE</b> |
|--------------|--------------------------------|------------------------------|
| 4214         | Boone Valley Electric Coop     | 0.00089047                   |
| 4220         | Cass Electric Coop             | 0.00003964                   |
| 4223         | Heartland Power Coop           | 0.00026776                   |
| 4249         | Farmers Electric Coop - Kalona | 0.00053556                   |

| <b>CO. #</b> | <b>RECs</b>                    | <b>DELIVERY TAX<br/>RATE</b> |
|--------------|--------------------------------|------------------------------|
| 4251         | Federated Rural Electric       | 0.00029447                   |
| 4253         | Franklin Rural Electric Coop   | 0.00061425                   |
| 4254         | Freeborn-Mower Cooperative     | 0.00188566                   |
| 4259         | Grundy County REC              | 0.00063081                   |
| 4260         | Grundy Electric Cooperative    | 0.00057506                   |
| 4266         | Hawkeye REC                    | 0.00044629                   |
| 4279         | Linn County REC                | 0.00127722                   |
| 4280         | Lyon Rural Electric Coop       | 0.00046143                   |
| 4286         | Maquoketa Valley Electric Coop | 0.00185391                   |
| 4287         | Consumers Energy               | 0.00103325                   |
| 4290         | Midland Power Cooperative      | 0.00086249                   |
| 4299         | Nishnabotna Valley REC         | 0.00045122                   |
| 4300         | North West Rural Electric Coop | 0.00033551                   |
| 4308         | Osceola Electric Coop          | 0.00020972                   |
| 4313         | Pleasant Hill Community Line   | 0.00028001                   |
| 4320         | Sac County Rural Electric Coop | 0.00073003                   |
| 4333         | Tri-County Electric Coop       | 0.00077954                   |
| 4348         | Western Iowa Power Coop        | 0.00112627                   |
| 4352         | Woodbury County REC            | 0.00072863                   |
| 4379         | Southwest Iowa Service Coop    | 0.00305638                   |

**2026 NATURAL GAS DELIVERY TAX RATES BY SERVICE AREA  
RATE CHANGES ONLY**

| <b>CO. #</b> | <b>MUNICIPAL GAS</b>      | <b>DELIVERY TAX<br/>RATE</b> |
|--------------|---------------------------|------------------------------|
| 5215         | Brighton Gas              | 0.00740529                   |
| 5238         | Coon Rapids Municipal Gas | 0.00004469                   |
| 5275         | Lamoni Municipal Gas      | 0.00086814                   |
| 5281         | Manilla Municipal Gas     | 0.00433227                   |
| 5317         | Rock Rapids Municipal Gas | 0.00013139                   |
| 5340         | Wayland Municipal Gas     | 0.00020700                   |
| 5349         | Winfield Municipal Gas    | 0.00098466                   |

  

| <b>CO. #</b> | <b>IOUs — GAS</b> | <b>DELIVERY TAX<br/>RATE</b> |
|--------------|-------------------|------------------------------|
| 5204         | Allerton Gas      | 0.03107436                   |
| 5335         | United Cities Gas | 0.00287495                   |

**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 May is 6.25%.

#### 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 May 9, 2026, 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 1.50% |
| 180-364 days . . . . .         | Minimum 1.45% |
| One year to 397 days . . . . . | Minimum 1.70% |
| More than 397 days . . . . .   | Minimum 1.85% |

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:

|                                        |       |
|----------------------------------------|-------|
| 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% |
| February 1, 2026 — February 28, 2026   | 6.25% |

|                                |       |
|--------------------------------|-------|
| March 1, 2026 — March 31, 2026 | 6.25% |
| April 1, 2026 — April 30, 2026 | 6.25% |
| May 1, 2026 — May 31, 2026     | 6.25% |
| June 1, 2026 — June 30, 2026   | 6.25% |

## ARC 0300D

## HUMAN SERVICES DEPARTMENT[441]

## Adopted and Filed Emergency

## Rulemaking related to uniform rules on agency procedure

The Department of Health and Human Services hereby amends Chapter 9, “Public Records and Fair Information Practices,” and adopts new Chapter 2504, “Rule Waivers,” Chapter 2505, “Fair Information Practices,” and Chapter 2506, “Contested Cases,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in 2026 Iowa Acts, Senate File 2463.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, 2026 Iowa Acts, Senate File 2463.

*Purpose and Summary*

This rulemaking rescinds rules 441—9.2(17A,22) and 441—9.12(17A,22), which were not automatically rescinded under the provisions of 2026 Iowa Acts, Senate File 2463.

These amendments also modify the Uniform Rules on Agency Procedure related to rule waivers (Chapter 2504), fair information practices (Chapter 2505) and contested cases (Chapter 2506) to maintain rules as determined necessary by the Department and to ensure that the Department follows all applicable State and federal requirements not currently contained in the Uniform Rules on Agency Procedure.

The reasons for the Department’s additions, exceptions, or amendments to the rules under agency number [7] are detailed below.

**Rule waivers (441—Chapter 2504):**

- Did not adopt language from 7—subrule 2504.3(2) allowing an evidentiary hearing on the denial of a request for waiver. Iowa Code section 17.9A(2) provides that determinations on waivers are within the sole discretion of an agency and therefore would not properly be raised before an administrative law judge (ALJ).

**Fair information practices (441—Chapter 2505):**

- Added definitions in rule 441—2505.1(17A,22) necessitated by the new rule content described below.

- Added new subrule 2505.5(4), which provides that individuals may request restrictions on the use of protected health information (PHI) pursuant to 45 CFR 164.522.

- Added new subrule 2505.7(1) relating to disclosures of PHI allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Added new subrule 2505.7(2) specifying that the Department will also maintain written policies for general uses of PHI for treatment, payment, and health care operations pursuant to HIPAA.

- Added new rule 441—2505.9(22,252G) to restore the provisions of rule 441—9.12(17A,22), which was allowed to be retained by the Department under the provisions of 2026 Iowa Acts, Senate File 2463.

**Contested cases (441—Chapter 2506):**

- Added definitions to rule 441—2506.2(17A) that pertain to subsequent additions to the Uniform Rules on Agency Procedure.

- Replaced language of subrule 2506.3(1) pertaining to time computation with more specific provisions to account for time tolled for State holidays that is not accounted for in the Iowa Code section referenced in the Uniform Rules on Agency Procedure.



- Added subrule 2506.4(3) regarding “parties-in-interest” to a contested case. The Department frequently encounters situations in which a contested case hearing is requested by individuals who are not constitutionally or statutorily entitled to a hearing. Adding this subrule provides clear guidelines for those situations.

- Added subrule 2506.4(4) outlining situations in which a contested case hearing will not be granted by the Department.

- Added subrule 2506.4(5), which accounts for situations in which all other remedies must be exhausted before a contested case hearing will be granted. For example, under Medicaid managed care, aggrieved enrollees must first go through the internal grievance process established by the Managed Care Organizations (MCOs) prior to requesting a contested case hearing from the State.

- Added subrule 2506.4(6) to accommodate federal regulations for appeals under Medicaid and the Supplemental Nutrition Assistance Program (SNAP). These regulations outline the methods in which appeals can be submitted and encompass more than electronic submission, which is the only method allowed under the Uniform Rules on Agency Procedure.

- Added subrule 2506.4(7), which sets a standard time frame to file appeals for situations in which another law or rule does not set forth the time frame.

- Added subrule 2506.4(8) regarding acceptance or denial of an appeal. The Department receives approximately 10,000 appeal requests per year, many from unrepresented individuals. This provision allows the Department to vet the requests to determine whether they should move forward, facilitating efficiency, while still preserving an individual’s right to appeal.

- Added subrule 2506.4(9), which allows the Department to designate and certify exactly which issues are to be decided in the contested case proceeding. This creates clarity early in the process yet allows the issues to be adjusted as the appeal progresses. This provision is not included in the Uniform Rules on Agency Procedure.

- Added subrule 2506.4(10) to incorporate federal requirements for SNAP hearings.

- Added a revised subrule 2506.5(2), which excludes language from the Uniform Rules on Agency Procedure that the Department has already clarified by previously adding subrule 2506.4(7). This clearly establishes that the Department bears the burden of identifying the issues of the matter. In addition, the revised subrule excludes language that would require the Department to set forth the telephone number and address of all representatives, which would require a system change for the Department.

- Revised language in subrule 2506.6(1), which reflects the fact that almost all the Department’s appeals go before an ALJ and therefore parties would only have to request an ALJ in the event one has not already been assigned.

- Added subrules 2506.10(3) and 2506.10(4) to ensure compliance with federal regulations for Medicaid and SNAP appeals, respectively.

- Did not adopt rule 441—2506.11(17A), which would require a formal petition in addition to the request for contested case hearing and would also require the Department to answer every appeal. Due to the Department’s high volume of appeals and current appeals system constraints, the requirements of this rule would be overly burdensome.

- Added conforming language to subrule 2506.12(1) to reflect the Department’s addition of subrule 2506.4(4) regarding filing methodology. This addition ensures compliance with federal Medicaid regulations.

- Added subrule 2506.18(1), which conforms to the federal regulations that dictate method of withdrawal from Medicaid appeals.

- Added subrule 2506.18(2), which conforms to the federal regulations that dictate method of withdrawal from SNAP appeals.

- Added language to subrule 2506.20(3) to explicitly state that:

- The Department may be represented by its own employees or employees of Department contractors at contested case hearings.

- Medicaid members may appoint an authorized representative to represent them in all Department matters as required by 42 CFR 435.923.

- Added subrule 2506.20(8) to help ensure that the terms of authorized representation are clearly defined and properly limited to protect Medicaid members' interests.
- Added subrule 2506.20(9) to require legal counsel to enter an appearance. Because the Department does not require petitions and answers, requiring counsel to enter an appearance is necessary to ensure the Department is aware of representation.
- Added subrule 2506.20(10), which provides that absent a mutual agreement by the parties, contested case hearings are closed to the public. This is necessary because many of the Department's appeals pertain to sensitive, confidential situations and information.
- Added paragraphs 2506.27(1)"a" through "e" to reflect the unique time frames required by State or federal law for Medicaid, SNAP, child abuse, and the Special Supplemental Nutrition Program for Women and Children (WIC) appeals of proposed decisions.
- Added the qualifier, "Unless otherwise required by law," to subrule 2506.27(2) to reflect the time frames described in subrule 2506.27(1).
- Added subrule 2506.27(7) to maintain the Department's existing requirement that a director's review on appeal is limited to the issues and record heard by the ALJ.
- Added rule 441—2506.32(17A) to implement federal requirements for the time frames within which contested cases must be held for Medicaid, division of spousal community resources for benefit determinations; SNAP; and WIC.
- Added rule 441—2506.33(17A) to reflect the federal requirements for an expedited review for Medicaid appeals.
- Added rule 441—2506.34(17A) to account for the federal requirements for administrative disqualifications hearings with respect to SNAP.
- Added rule 441—2506.35(17A) containing federal requirements for continuation and reinstatement of benefits in certain circumstances and allowing the Department to recoup benefits in the event an adverse action is overturned.

*Reason for Adoption of Rulemaking Without  
Prior Notice and Opportunity for Public Participation*

Pursuant to Iowa Code section 17A.4(3), the Department finds that notice and public participation are unnecessary or impractical because 2026 Iowa Acts, Senate File 2463, section 5, authorizes emergency rulemaking to provide for additions, exceptions, or amendments to the Uniform Rules on Agency Procedure.

*Reason for Waiver of Normal Effective Date*

Pursuant to Iowa Code section 17A.5(2)"b"(1)(c), the Department also finds that the normal effective date of this rulemaking, 35 days after publication, should be waived and the rulemaking made effective July 1, 2026, because 2026 Iowa Acts, Senate File 2463, section 5, authorizes emergency rulemaking for the purpose stated above.

The new Uniform Rules of Agency Procedure are effective as of January 13, 2026, which means there are inconsistencies between the Uniform Rules and the Department's rules pertaining to waivers of administrative rules, fair information practices, and contested cases. Earlier adoption of this rulemaking will allow the Department to ensure all State and federal requirements encompassed within those chapters are followed.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on May 5, 2026.

*Concurrent Publication of Notice of Intended Action*

In addition to its adoption on an emergency basis, this rulemaking has been initiated through the normal rulemaking process and is published herein under Notice of Intended Action as **ARC 0303D** to allow for public comment.

*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 2504.

*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 July 1, 2026.

The following rulemaking action is adopted:

- ITEM 1. Rescind and reserve rule **441—9.2(17A,22)**.
- ITEM 2. Rescind and reserve rule **441—9.12(22,252G)**.
- ITEM 3. Adopt the following new 441—Chapter 2504:

CHAPTER 2504  
RULE WAIVERS

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.

**441—2504.3(17A) Evaluation.**

**2504.3(2)** The agency will evaluate the petition in accordance with Iowa Code section 17A.9A. The agency may request additional information from the petitioner or any person as part of its evaluation of the petition.

7—paragraphs 2504.3(2) “a” and “b” are not adopted.

- ITEM 4. Adopt the following new 441—Chapter 2505:

CHAPTER 2505  
FAIR INFORMATION PRACTICES

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.

**441—2505.1(17A,22) Definitions.** As used in this chapter:

“*Client*” means a person who has applied for or received services or assistance from the agency.

“*Disclosure*” means the same as defined in 45 CFR §160.103 as amended to June 25, 2024.

*“Health care operations,”* for covered entities in the agency, means the same as defined in 45 CFR §164.501 as amended to March 26, 2013.

*“Payment,”* with respect to protected health information, means the same as defined in 45 CFR §164.501 as amended to March 26, 2013. For the agency’s purposes, “payment” applies to subjects for whom health care coverage is provided under the Medicaid program or the hawki program.

*“Protected health information”* or *“PHI”* means the same as defined in 45 CFR §160.103 as amended to July 1, 2026.

*“Record”* means the whole or a part of a “public record” as defined in Iowa Code section 22.1 that is owned by or in the physical possession of the agency.

*“Subject”* means the person who is the subject of the record, whether living or deceased.

*“Treatment”* means the same as defined in 45 CFR §164.501 as amended to March 26, 2013.

*“Use,”* with respect to PHI, means the same as defined in 45 CFR §160.103 as amended to July 1, 2026.

**441—2505.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination.**

**2505.5(4)** The agency shall also allow individuals to request restrictions on the use or disclosure of PHI and alternative means of confidential communication, consistent with 45 CFR §164.522 as amended to July 1, 2026. The agency will maintain written procedures for processing such requests and document any granted restrictions.

**441—2505.7(17A,22) Consent to disclosure by the subject of a confidential record.**

**2505.7(1)** The agency shall include provisions for disclosures of confidential information consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any applicable state or federal law as amended to July 1, 2026, including:

- a.* Emergency exceptions;
- b.* Disclosures requiring opportunity to agree or object;
- c.* Disclosures when an individual is not present;
- d.* Disaster relief disclosures; and
- e.* Routine disclosures for:
  - (1) Internal operations;
  - (2) Contractors and agents working on behalf of the agency;
  - (3) Judicial or administrative proceedings;
  - (4) Medicaid billing;
  - (5) Child support recovery; and
  - (6) Research purposes.

**2505.7(2)** Additionally, the agency shall maintain written policies for general uses and disclosures of PHI for treatment, payment, and health care operations.

**441—2505.9(22,252G) Personally identifiable information.** The nature and extent of personally identifiable information collected by the agency varies by the type of record. This rule describes personally identifiable information collected, maintained, and retrieved by the agency by personal identifiers in record systems and the legal authority for the collection of that information. This rule also identifies the legal authority for keeping some or all of the collected personally identifiable information confidential.

**2505.9(1)** Agency administrative records.

*a.* Personnel records. These records contain information about employees, families and dependents, and applicants for positions with the agency. Some of this information is confidential under Iowa Code section 22.7(11) and 22.7(18).

*b.* Fiscal records. These records contain itemized vouchers collected from individuals pursuant to Iowa Code section 8A.514. Some of this information is confidential under Iowa Code section 22.7(11) and 22.7(18).

c. Litigation files. These files or records contain information regarding litigation or anticipated litigation, which includes judicial and administrative proceedings. The records include briefs, depositions, docket sheets, documents, correspondence, attorney's notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. The files contain materials that are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing copies of pleadings and other documents filed in litigation should obtain them from the clerk of the appropriate court that maintains the official copy. These records are confidential as outlined in Iowa Code sections 217.30, 22.7(4) and 622.10.

**2505.9(2) Program records.**

a. Adoption investigator certification. These records are collected pursuant to Iowa Code chapter 600.

b. Adoption program records. These records are collected pursuant to Iowa Code sections 600.8 and 600.16. These records are confidential as outlined in Iowa Code sections 600.16 and 600.24.

c. Appeals. These records are collected pursuant to Iowa Code section 217.1A. Some of these records are confidential as outlined in Iowa Code section 217.1A. Each appeal to the department will be governed by the specific state and federal laws that control it.

d. AIDS drug reimbursement program. These records are collected for purposes of implementing a federal grant program authorized by HR 1827 as amended to June 27, 1987. Certain patient records are confidential as outlined in Iowa Code section 141A.9.

e. Brain injury service program recipients. These records are collected pursuant to Iowa Code section 135.22B. These records are confidential as outlined in Iowa Code section 135.22(2).

f. Congenital and inherited disorders. These records are collected pursuant to Iowa Code chapter 136A. These records are confidential as outlined in Iowa Code section 136A.7.

g. Central registry for brain or spinal cord injuries. These records are collected pursuant to Iowa Code section 135.22. Except for statistical reports, these records are maintained as confidential pursuant to Iowa Code section 135.22.

h. Child abuse program. These records are collected pursuant to Iowa Code section 235A.14. These records are confidential as outlined in Iowa Code sections 235A.13, 235A.15, 235A.16, and 235A.17.

i. Child care assistance client records. These records are collected pursuant to Iowa Code chapter 237A. These records are confidential as outlined in Iowa Code section 237A.13.

j. Child care facility licensing. These records are collected pursuant to Iowa Code chapter 237A. Some of these records are confidential as outlined in Iowa Code section 237A.7.

k. Childhood lead poisoning prevention program. These records are collected pursuant to Iowa Code sections 135.100 through 135.105. Certain records are confidential as outlined in Iowa Code chapter 139A.

l. Child support recovery program. These records are collected pursuant to Iowa Code chapters 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, and 252K and sections 144.13, 144.26, 232.147, 234.39, 595.4, 598.22B and 600.16A. These records are confidential as outlined in Iowa Code sections 252B.9 and 252G.5; 42 U.S.C. §654(26) as amended to July 1, 2026; 42 U.S.C. §654a(d) as amended to July 1, 2026; and 45 CFR §303.21 and §307.13 both as amended to July 1, 2026.

m. Chronic disease prevention and management programs. These records are collected pursuant to Iowa Code section 135.11(1). Certain medical information in these records is confidential as outlined in Iowa Code section 22.7(2).

n. Collection service center payment. These records are collected pursuant to Iowa Code sections 252B.9, 252B.13A and 252B.16. These records are confidential as outlined in Iowa Code section 252B.9(2) and 42 U.S.C. §654a(d) and 45 CFR §307.13 both as amended to July 1, 2026.

o. Criminal and juvenile justice information. These records are collected pursuant to Iowa Code sections 216A.136 and 216A.138 and through interagency agreements.

p. Dental health program. These records are collected pursuant to Iowa Code section 135.11(14). Certain medical information in these records is confidential as outlined in Iowa Code section 22.7(2).

- q.* Dependent adult abuse program. These records are collected pursuant to Iowa Code section 235B.1. These records are confidential as outlined in Iowa Code section 235B.1.
- r.* Domestic abuse death review. These records are collected pursuant to Iowa Code section 135.110. These records are confidential as outlined in Iowa Code section 135.111.
- s.* Emergency medical services. These records are collected pursuant to Iowa Code chapter 147A.
- t.* Environmental health program. These records are collected pursuant to Iowa Code section 135.11(1); PL 96-510, Section 104(d)(1); 40 CFR 763 effective June 28, 1983; and 40 CFR 761 effective May 31, 1979, and both as amended to July 1, 2026, dealing with asbestos, PCB and other environmental health factors. Certain medical information in the work-related disease program file may be confidential as outlined in Iowa Code section 22.7(2). Certain asbestos and PCB inspection records are collected under contract with the federal Environmental Protection Agency, and requests for such records will be referred to that agency.
- u.* Family investment program client records. These records are collected pursuant to Iowa Code section 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §602(a)(1) and §1306a as amended to July 1, 2026.
- v.* Food assistance client files. These records are collected pursuant to Iowa Code section 234.6. These records are confidential as outlined in Iowa Code section 217.30; 7 U.S.C. §2020(e)(8) as amended to July 1, 2026; and 7 CFR §272.1(c) and (d) as amended to June 23, 2000.
- w.* Foster care client/service files. These records are collected pursuant to Iowa Code sections 237.3 through 237.5. These records are confidential as outlined in Iowa Code section 237.9.
- x.* Foster care facility licensing. These records are collected pursuant to Iowa Code chapter 237. Some of these records are confidential as outlined in Iowa Code section 237.9.
- y.* Foster care review board files. These records are collected pursuant to Iowa Code section 237.17. Some of these records are confidential as outlined in Iowa Code section 237.21.
- z.* Hawki client files. These records are collected pursuant to Iowa Code section 514I.4. These records are confidential as outlined in Iowa Code section 514I.4 and 42 CFR §457.1110 as amended to January 1, 2001.
- aa.* Human rights advocacy files. These records are collected pursuant to Iowa Code chapter 216A; the Omnibus Budget Reconciliation Act, PL 97-35 as amended to July 1, 2026; Juvenile Justice and Delinquency Prevention Act, PL 93-415 as amended to July 1, 2026; and the Victims Compensation and Assistance Act, PL 98-473 as amended to July 1, 2026. These records are confidential as outlined in Iowa Code section 22.7(18).
- ab.* Long-term and managed care ombudsman complaints. These records are collected pursuant to Iowa Code sections 135C.37 and 231.42. These records are confidential as outlined in Iowa Code sections 135C.37 and 231.42.
- ac.* Maternal and child health program. These records are collected pursuant to Iowa Code section 135.11(13). Records that contain medical information are confidential pursuant to Iowa Code section 22.7(2).
- ad.* Medicaid clients. These records are collected pursuant to Iowa Code section 249A.4. These records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §1396a(7) as amended to July 1, 2026; and 42 CFR §431.300 through 307 as amended to November 13, 1996.
- ae.* Medicaid provider information. These records are collected pursuant to Iowa Code section 249A.4. Some of these records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §1396a(7) as amended to July 1, 2026; and 42 CFR §431.300 through 307 as amended to November 13, 1996.
- af.* Newborn and infant hearing screening program. These records are collected pursuant to Iowa Code section 135.131. Information that identifies an individual patient is confidential as outlined in Iowa Code section 135.131.
- ag.* Nutrition and WIC (Special Supplemental Nutrition Program for Women, Infants and Children) program. These records are collected pursuant to Iowa Code section 135.11(1) and Chapter 17 of the federal Child Nutrition Act of 1966 as amended to January 5, 2023. These records are confidential as outlined in 7 CFR 246 as amended to July 1, 2026, and Iowa Code section 22.7(2).

*ah.* Radiological health program. These records are collected pursuant to Iowa Code chapters 136B and 136C. Certain records are confidential as outlined in rule 641—39.6(136C).

*ai.* Refugee health program. These records are collected pursuant to Iowa Code section 135.11(1) and Section 412(c)(3) of the federal Immigration and Naturalization Act as amended to July 1, 2026. Records that contain medical information are confidential pursuant to Iowa Code section 22.7(2).

*aj.* Refugee resettlement client records. These records are collected pursuant to Iowa Code section 217.1A. These records are confidential as outlined in Iowa Code section 217.30 and 45 CFR §400.27 as amended to March 22, 2000.

*ak.* Reportable diseases and other diseases and health conditions, including lead and other heavy metal poisonings. These records are collected pursuant to Iowa Code chapter 139A. Except for statistical reports, these records are confidential as required by Iowa Code chapter 139A.

*al.* Reportable sexually transmitted diseases or infections. These records are collected pursuant to Iowa Code chapter 139A. Except for statistical reports, these records are confidential as required by Iowa Code chapter 139A.

*am.* State institution resident records. These records are collected pursuant to Iowa Code section 218.1. These records are confidential as outlined in Iowa Code sections 218.22, 229.24 and 229.25.

*an.* State supplementary assistance clients. These records are collected pursuant to Iowa Code chapter 249. Some of these records are confidential as outlined in Iowa Code section 217.30.

*ao.* Substance use client records. These records are collected pursuant to Iowa Code chapters 125 and 218 and sections 234.6 and 249A.4. These records are confidential as outlined in Iowa Code section 125.93; 42 U.S.C. §29dd-2 and ee.3 as amended to January 1, 2024; 42 CFR Part 2 as amended to April 16, 2024; and 38 U.S.C. §4132 as amended to July 1, 2026.

*ap.* Substance use program licensing complaints. These records are collected pursuant to Iowa Code chapter 125. Certain information in these records may be confidential as outlined in Iowa Code section 22.7(2) and 22.7(18).

*aq.* Title IV-E foster care and adoption assistance client files. These records are collected pursuant to Iowa Code sections 217.1A and 600.17 through 600.22. These records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §671(a)(8) as amended to July 1, 2026; and 45 CFR §1355.30(1) as amended to January 20, 2016.

*ar.* Veterinary public health. These records are collected pursuant to Iowa Code chapter 139A. Certain medical information in these records may be confidential as outlined in Iowa Code chapter 139A.

*as.* Vital records. These records are collected pursuant to Iowa Code chapter 144, including records of births, deaths, fetal deaths, adoptions, marriages, divorces, annulments and related data and correspondence. These records are confidential as outlined in Iowa Code section 144.43.

**2505.9(3)** Other restricted data contained in agency client records include the following.

*a.* *Department of revenue information.* These records are collected pursuant to Iowa Code sections 252B.5 and 252B.9. These records are confidential as outlined in Iowa Code sections 421.17 and 422.20(1).

*b.* *Department of workforce development information.* These records are collected pursuant to Iowa Code chapters 239B and 249A and section 252B.9. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §503(d) and (e) as amended to July 1, 2026.

*c.* *Income and eligibility verification system.* These records are collected pursuant to Iowa Code chapters 239B and 249A and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §1230b-7 as amended to July 1, 2026.

*d.* *Department of public safety information.* These records are collected pursuant to Iowa Code sections 237.8, 237A.5 and 252B.9. These records are confidential as outlined in Iowa Code sections 692.2, 692.3, 692.8 and 692.18.

*e.* *Federal tax return information.* These records are collected pursuant to Iowa Code chapters 239B, 249A and 252B and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 422.20(2) and 26 U.S.C. §6103 as amended to July 1, 2026.

*f. Juvenile court information.* These records are collected pursuant to Iowa Code chapter 232 and section 234.6. These records are confidential as outlined in Iowa Code sections 232.48, 232.97 and 232.147 through 232.151.

*g. Peer review organization.* These records are collected pursuant to Iowa Code section 249A.4. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §1320c-9 as amended to July 1, 2026.

*h. United States Department of Health and Human Services information.* These records are collected pursuant to Iowa Code chapters 239B, 249, 249A and 252B and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 CFR Part 401.134(c) as amended to October 1, 2002.

These rules are intended to implement Iowa Code chapters 17A, 22, 135, 217, 228, and 252G and the Health Insurance Portability and Accountability Act of 1996 as amended to July 1, 2026.

ITEM 5. Adopt the following new 441—Chapter 2506:

#### CHAPTER 2506 CONTESTED CASES

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.

##### **441—2506.2(17A) Definitions.**

*“Enrollee”* means any applicant for or recipient of benefits or services provided by a program administered by the agency or on the agency’s behalf.

*“Good cause,”* for purposes of this chapter, has the same meaning as “good cause” for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

*“Household”* means the same as defined in 7 CFR §273.1 as amended to July 1, 2026.

*“Intentional program violation”* means the same as established in 7 CFR §273.16 as amended to August 1, 2024.

*“Medicaid”* means Iowa’s medical assistance program administered under Iowa Code chapter 249A.

*“Party-in-interest”* refers to the party, including enrollees, whose rights or obligations are the subject of a contested case hearing under this chapter. Parties-in-interest may or may not be the appellant.

##### **441—2506.3(17A) Time obligations.**

**2506.3(1)** In computing any time period specified in this chapter, the period:

- a.* Excludes the day of the event that triggers the period;
- b.* Includes every day of the time period (including Saturdays, Sundays, and holidays on which the agency is closed); and
- c.* Includes the last day of the period, but if the last day is a Saturday, Sunday, or a legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.

##### **441—2506.4(17A) Electronic requests for contested case proceeding.**

**2506.4(3)** *When a contested case hearing will be granted.* A person will be granted a contested case hearing if the party-in-interest fulfills all the following requirements:

- a.* The party-in-interest is entitled to a contested case hearing;
- b.* The party-in-interest has an ongoing, specific and personal interest in the outcome of the contested case hearing; and
- c.* The party-in-interest meets all the other requirements contained in these rules.

**2506.4(4)** *When a contested case hearing will not be granted.* A contested case hearing will not be granted when one of the following issues is appealed:

- a.* Patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders as amended to July 1, 2026.



b. Children have been removed from or placed in a specific foster care setting or preadoptive placement.

c. A final decision from a previous hearing with a presiding officer has been implemented.

d. A request for a waiver of administrative rule has been denied.

**2506.4(5) Exhaustion of remedies.** A person will only be granted a contested case hearing if the person has exhausted all other appeal remedies available. A person should refer to program-specific provisions for the appropriate procedures applicable to the specific program.

**2506.4(6) Exception for requesting a contested case proceeding hearing for Supplemental Nutrition Assistance Program (SNAP) and Medicaid appeals.** A person entitled to a contested case or hearing for Medicaid and SNAP appeals may request it:

a. By submitting an electronic request through the agency's website;

b. By telephone;

c. By mail;

d. In person; or

e. Through other commonly available electronic means (such as email).

**2506.4(7) Time to file appeals.** For all requests for contested case hearing, and unless federal or state law provides otherwise, the person must file the request for contested case hearing on or before the thirtieth day following the date of notice of the action being appealed. If such an appeal is made more than 30 days, but less than 90 days, after the date of notice, the director or director's designee may, at the director's or designee's sole discretion, allow a contested case hearing if the delay was for good cause, substantiated by the person.

**2506.4(8) Acceptance or denial of appeal.** The agency will determine with reasonable promptness whether the person who has filed the appeal is entitled to a contested case hearing. If a request is accepted, the agency will designate the issues. If a request is denied, the agency will provide written notice of and the reasons for the denial. On or before the thirtieth day following the denial, the person requesting the appeal may provide additional information related to the person's asserted right to a contested case hearing and request reconsideration of the denial.

**2506.4(9) Designation of issues.**

a. Initial designation. The issues initially designated by the agency will be certified to the department of inspections, appeals, and licensing (DIAL) and be identified in the notice of hearing.

b. Additional designation of issues. If any person believes additional issues should be designated, the person shall identify the additional issues within the following timelines. The presiding officer shall determine whether all issues have properly been preserved.

(1) Child abuse and dependent adult abuse registry appeals. For a child abuse and dependent adult abuse registry appeal, the person shall identify additional issues at least 30 days before the date of hearing.

(2) Appeals set on or before the fifteenth day following the notice of hearing. If the hearing is on or before the fifteenth day following the date of the notice of hearing, the person shall identify any additional issues at the hearing.

(3) All other appeals. For all other appeals not identified in this paragraph, the person shall identify the additional issues on or before the fifteenth day following the date of the notice of hearing.

**2506.4(10) Agency responsibilities on SNAP hearing requests.** Upon request, the agency will make available without charge the specific materials necessary for a household or its representative to determine whether a hearing should be requested or to prepare for a hearing. If the person making the request speaks a language other than English and the agency is required by 7 CFR §272.4(c)(3) as amended to July 1, 2026, to provide bilingual staff or interpreters who speak the appropriate language, the agency will ensure that the hearing procedures are verbally explained in that language. Upon request, the agency will also help a household with its hearing request. If a household makes an oral request for a hearing, the agency will complete the procedures necessary to start the hearing process. Households will be advised of any legal services available that can provide representation at the hearing. This rule does not preclude the provision of these services in all other appeals.

**441—2506.5(17A) Notice of hearing.**

**2506.5(2)** *Contents.* The notice of hearing must state:

- a. The time, place, and nature of the hearing;
- b. The legal authority and jurisdiction under which the hearing is to be held;
- c. The particular sections of the statutes and rules involved;
- d. The procedural rules governing conduct of the contested case proceeding;
- e. The procedural rules governing informal settlement;
- f. The identity of the presiding officer, if known, or, if not, a description of who will serve as presiding officer; and
- g. The deadline to request under Iowa Code section 17A.11 and rule 441—2506.6(17A), that the presiding officer be an administrative law judge (ALJ).

**441—2506.6(17A) Presiding officer.**

**2506.6(1)** If an ALJ is not assigned, any party that wants an ALJ employed by DIAL to serve as the presiding officer must file a request. The deadline for that request is 20 days after service of a notice of hearing that identifies someone other than an ALJ as the presiding officer.

**441—2506.10(17A) Consolidation—severance.**

**2506.10(3)** *Medicaid member appeals.* Notwithstanding subrule 2506.10(1), for Medicaid member appeals, the agency and the presiding officer acting on behalf of the agency:

- a. May respond to a series of individual requests for hearing by conducting a single group hearing;
- b. May consolidate hearings only in cases in which the sole issue involved is one of federal or state law or policy;
- c. Must follow the policies of 42 CFR, Chapter IV, Subchapter C, Part 431, Subpart E, as amended to July 1, 2026;
- d. Must permit each person to present the individual's own case or be represented by the individual's authorized representative.

**2506.10(4)** *SNAP appeals.* The agency may respond to a series of individual requests for hearings by conducting a single group hearing. The agency may consolidate only cases where individual issues of fact are not disputed and where related issues of state or federal law, regulation, or policy are the sole issues being raised. In all group hearings, the regulations governing individual hearings must be followed. Each individual household shall be permitted to present its own case or have its case presented by a representative.

**441—2506.11(17A) Pleadings.** This rule is not adopted.**441—2506.12(17A) Electronic service and filing of pleadings and other papers.**

**2506.12(1)** *Filing and service electronically.* Except as provided in subrule 2506.4(6), every pleading, motion, document, or other paper that is filed or served shall be executed electronically whenever possible. Filing or service by a nonelectronic method can only be upon a showing to the presiding officer of undue hardship to use electronic mail.

**441—2506.18(17A) Withdrawals.**

**2506.18(1)** *Medicaid appeal withdrawals.* For Medicaid member appeals, the agency must record the individual's statement and telephonic signature for telephonic hearing withdrawals. For telephonic, online and other electronic withdrawals, the agency must send the affected person written confirmation, via regular mail or electronic notification in accordance with the individual's election.

**2506.18(2)** *SNAP appeal withdrawals.* For oral withdrawal of SNAP appeals, the agency must provide a written notice to the household within ten days of the household's request confirming the withdrawal request and providing the household with an opportunity to request a hearing. The written notice must advise the household it has ten days from the date it receives the notice to advise the agency of its desire to request, or reinstate, the hearing. If the household timely advises the agency that it wishes to reinstate the fair hearing, the agency must provide the household with a fair hearing, within the time

frames specified in 7 CFR §273.15(c) as amended to July 1, 2026, and beginning the date the household advises the agency that it wishes to reinstate its request. The agency must reinstate a fair hearing as requested from a household at least once. The agency must not deny a household's request for a fair hearing if the household is aggrieved by an agency action that differs from the reinstated action.

**441—2506.20(17A) Hearing procedures.**

**2506.20(3) Representation.** Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, limited-liability companies, and associations may be represented by any member, officer, director, or duly authorized agent. The agency may be represented by agency employees or employees of an agency contractor. Any party may be represented by an attorney, an authorized representative appointed pursuant to rule 441—76.9(249A), an authorized representative appointed pursuant to subrule 2506.20(8), or another person authorized by law. An attorney admitted pro hoc vice in accordance with Iowa Court Rules to practice in an agency administrative action in accordance with Iowa Court Rule 31.14 is obligated to have an in-state attorney present at every interaction with the presiding officer.

**2506.20(8) Authorized representatives.**

*a. Regulations.* The provisions of this subrule only apply to the extent the standards expressed in this subrule are not in conflict with other state or federal law.

*b. Designation of authority.* Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, shall be sufficient for a delegate to serve as authorized representative under this chapter. A person who is not designated a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for a person in an appeal under this chapter shall provide a written, signed designation of authority to the agency with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

*c. Written designation.* For a person other than an attorney seeking to act as an authorized representative of a party-in-interest in a Medicaid managed care appeal, the authorized representative's written designation of authority pursuant to paragraph 2506.20(8)"b" shall be on an authorized representative form prescribed by the agency. This form is required for all managed care appeals, including those handled through the expedited appeals process. Failure to provide the form or legal documentation may result in denial of the appeal request.

**2506.20(9) Appearance by attorney.** Legal counsel appearing on behalf of any person in a proceeding under this chapter shall enter an appropriate written appearance.

**2506.20(10) Closed to public.** Contested case hearings are closed to the public, and unless otherwise provided by state or federal law, only the parties, their representatives, permissible intervenors, and witnesses may be present for a contested case hearing in the absence of mutual agreement of the parties.

**441—2506.27(17A) Appeals and review.**

**2506.27(1) Appeal by party.**

*a.* Unless otherwise prohibited by law, any adversely affected party may appeal a proposed decision to the agency within 30 days after the decision is issued.

*b.* A managed care organization (MCO) appealing a proposed decision reversing an adverse benefit determination shall request the director's review within 72 hours from the date it received notice of the proposed decision.

*c.* In Medicaid and SNAP appeals, an appeal of a proposed decision to the agency shall be made within 14 days after the date the decision is issued.

*d.* In appeals from a child abuse assessment under Iowa Code section 235A.19, an appeal of a proposed decision to the agency shall be made within ten days after the date the decision is issued.

*e.* In WIC appeals, an appeal of a proposed decision to the agency shall be made within ten days after the date the decision is issued.

**2506.27(2) *Review.*** Unless otherwise prohibited by law, the agency may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

**2506.27(7) *Limited record.*** The director's review on appeal shall be limited to the issues and record before the contested case hearing presiding officer.

**441—2506.32(17A) Timelines for contested case hearings.**

**2506.32(1) *Medical assistance.*** In cases involving the determination of medical assistance, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 42 CFR §431.244(f) as amended to December 8, 2021.

**2506.32(2) *Community spouse resource allowance.*** In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

**2506.32(3) *SNAP.*** In cases involving SNAP, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 7 CFR §273.15(c) as amended to July 1, 2026.

**2506.32(4) *WIC.*** In cases involving WIC, the hearing shall be held within three weeks from the date the request for hearing was received.

**441—2506.33(17A) Medical assistance expedited review.**

**2506.33(1) *Expedited review criteria.*** An appellant to a medical assistance appeal may, at any time, file with the agency a request for expedited review of the appeal. Expedited review shall be granted pursuant to 42 CFR §438.410 as amended to August 1, 2024, for an MCO appeal or 42 CFR §431.224 as amended to August 1, 2024, for a non-MCO appeal.

**2506.33(2) *Managed care expedited proceedings.***

*a.* If the appellant is granted an expedited review, all subsequent proceedings shall also be expedited without an additional request if the appeal request indicates that the MCO appeal was expedited and provides the basis for expedited relief.

*b.* When review is expedited pursuant to this rule, the presiding officer shall issue a proposed decision as expeditiously as the enrollee's health condition requires but no later than three working days after the agency receives from the MCO the case file and information for any appeal of a denial of a service that, as indicated by the MCO:

(1) Meets the criteria for expedited resolution but was not resolved within the time frame for expedited resolution; or

(2) Was resolved within the time frame for expedited resolution but reached a decision wholly or partially adverse to the enrollee.

**2506.33(3) *Medicaid eligibility or preadmission and annual resident review expedited proceedings.*** For expedited appeals related to Medicaid eligibility or preadmission and annual resident review requirements, the presiding officer shall issue a proposed decision as expeditiously as possible but no later than seven working days after the agency receives a request for an expedited fair hearing.

**2506.33(4) *Medicaid-covered benefits or services expedited proceedings.*** For expedited appeals related to Medicaid-covered benefits or services, the presiding officer shall issue a proposed decision as expeditiously as possible but no later than provided in paragraph 2506.33(2) "b."

**2506.33(5) *Final decision for expedited proceeding.*** The agency will issue its final decision in accordance with this rule, except as provided by subrule 2506.33(2).

**2506.33(6) *Notification if expedited relief is granted or denied.*** The agency will notify the appellant as expeditiously as possible whether the request for expedited relief is granted or denied. Such notice will be provided orally or through electronic means to the extent consistent with federal and state law. If oral notice is provided, the agency will follow up with written notice, which may be through electronic means to the extent consistent with federal and state law.

**441—2506.34(17A) SNAP administrative disqualification hearings.** An intentional program violation is determined through a SNAP administrative disqualification hearing; through a court conviction; or through individual signs and returns a form prescribed by the agency, which may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both in accordance with the procedures outlined in this rule and in 7 CFR §273.16(e) and (f) as amended to December 8, 2021.

**2506.34(1)** When a case is referred for an administrative disqualification hearing, the agency will mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning a waiver of right to an administrative disqualification hearing.

**2506.34(2)** By signing a waiver of right to an administrative disqualification hearing, the individual:

- a.* Waives the right to an administrative disqualification hearing;
- b.* Consents to the SNAP disqualification period designated in the waiver of right to an administrative disqualification hearing and a reduction of benefits for the period of disqualification; and
- c.* Acknowledges that remaining household members, if any, may be held responsible for repayment of the resulting claim.

**2506.34(3)** An administrative disqualification hearing will be scheduled if the individual does not sign and mail or fax the waiver of right to an administrative disqualification hearing to the agency within ten days of receipt of the written notification stating the individual can waive the right to an administrative disqualification hearing. The date on which the written notification is received is considered to be five days after the date on the notification unless the individual shows the notification was not received within the five-day period.

**2506.34(4)** An individual who waives the right to an administrative disqualification hearing will be subject to the same penalties as an individual found to have committed an intentional program violation in an administrative disqualification hearing.

**441—2506.35(17A) Continuation and reinstatement of benefits.**

**2506.35(1)** *Programs for which no federal or state law applies.* For all assistance programs for which there is no contravening federal or state law, benefits or services shall not be suspended, reduced, restricted, or discontinued, nor shall a license, registration, certification, approval, or accreditation be revoked or other adverse action taken pending a final decision when:

- a.* An appeal is filed before the effective date of the intended action; or
- b.* The appellant requests a hearing within ten days of receipt of a notice to suspend, reduce, restrict, or discontinue benefits or services. The date on which the notice is received is considered to be five days after the date on the notice unless the appellant shows the notice was not received within the five-day period.

**2506.35(2)** *Sole issue is state or federal law or policy.* Benefits or services continued pursuant to subrule 2506.35(1) may be suspended, reduced, restricted, or discontinued if the presiding officer determines at the contested case hearing that the sole issue is one of state or federal law or policy and the agency has notified the enrollee in writing that services are to be suspended, reduced, restricted, or discontinued pending the proposed decision.

**2506.35(3)** *Recoup cost of services or benefits.* The agency or MCO may recoup the cost of benefits or services provided pursuant to this chapter and 7—Chapter 2506 if the adverse action appealed from is affirmed, consistent with state and federal law.

[Filed Emergency 5/5/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0308D****INSURANCE DIVISION[191]****Adopted and Filed Emergency****Rulemaking related to licensing of public adjusters**

The Insurance Division hereby amends Chapter 55, “Licensing of Public Adjusters,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 522C and 2026 Iowa Acts, House File 2582, section 4.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 522C as amended by 2026 Iowa Acts, House File 2582.

*Purpose and Summary*

This rulemaking addresses the financial responsibility requirements for adjusters that had been set out in the Iowa Code and in the Insurance Division Bulletin. This rulemaking allows for expanded methods by which adjusters may comply with the financial responsibility requirements. The financial responsibility requirements could be the subject of frequent adjustments; therefore, the rulemaking process affords greater flexibility in addressing such changes. All references to Iowa Code chapter 522C herein are to that chapter as amended by 2026 Iowa Acts, House File 2582.

*Reason for Adoption of Rulemaking Without  
Prior Notice and Opportunity for Public Participation*

Pursuant to Iowa Code section 17A.4(3), the Division finds that notice and public participation are unnecessary or impractical because statute so provides.

*Reason for Waiver of Normal Effective Date*

Pursuant to Iowa Code section 17A.5(2)“b”(1)(a), the Division also finds that the normal effective date of this rulemaking, 35 days after publication, should be waived and the rulemaking made effective on May 5, 2026, because 2026 Iowa Acts, House File 2582, section 4, provides for emergency rulemaking. This rule is determined to be necessary by the agency to ensure fair and professional adjuster practices and consistent financial responsibility requirements among licensed individuals working in the claims environment.

*Adoption of Rulemaking*

This rulemaking was adopted by the Division on May 5, 2026.

*Concurrent Publication of Notice of Intended Action*

In addition to its adoption on an emergency basis, this rulemaking has been initiated through the normal rulemaking process and is published herein under Notice of Intended Action as **ARC 0304D** to allow for public comment.

*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 Division for a waiver of the discretionary provisions, if any, pursuant to 191—Chapter 4.

*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 became effective on May 5, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind rule 191—55.10(522C) and adopt the following **new** rule in lieu thereof:

**191—55.10(522C) Evidence of financial responsibility.**

**55.10(1)** Prior to the issuance of a license as an adjuster and for the duration of the license, an applicant shall secure evidence of financial responsibility in a format prescribed by the commissioner. Evidence of financial responsibility must provide coverage for damages resulting from an adjuster's erroneous act, failure to act, fraud, acts in violation of Iowa Code chapter 522C, or unfair or deceptive act or practice as determined pursuant to Iowa Code chapter 507B. An independent contractor or an Internal Revenue Service 1099 staff adjuster must maintain the independent contractor's or the Internal Revenue Service 1099 staff adjuster's own individual bond or other qualifying financial responsibility unless specifically employed and covered by the adjuster business entity's qualifying bond or certificate of insurance. The bond or certificate of insurance must be issued by an insurer authorized to transact business in Iowa. Financial responsibility may be satisfied through one of the following options:

*a. Surety bonds.*

(1) Individual bond. The bond must be individually written in an amount of no less than \$50,000 and issued in favor of the state of Iowa.

(2) Business entity bond. A scheduled or blanket bond provided for an adjuster business entity employing multiple licensed adjusters with a per occurrence limit of \$50,000 and a total aggregate exposure limit in any one policy period. Bond amounts according to the number of adjusters are as follows:

| Number of Adjusters | Bond Amount                                                                    |
|---------------------|--------------------------------------------------------------------------------|
| 2-20                | \$250,000, or no less than five times the required individual bond of \$50,000 |
| 21-40               | \$500,000, or no less than ten times the required individual bond of \$50,000  |
| 41 or more          | \$1 million, or no less than 20 times the required individual bond of \$50,000 |

b. Professional liability or errors and omissions certificate of insurance. The coverage provides sufficient coverage for professional liability or acts or omissions in the performance of adjusting services for all affiliated adjusters performing activities pursuant to Iowa Code chapter 522C, individually or on behalf of the business entity, in an amount of no less than \$50,000 per adjuster and with an aggregate limit of \$1 million.

c. Irrevocable letter of credit. The irrevocable letter of credit must:

(1) Be issued by a qualified financial institution chartered under federal or state law, regulated and supervised by federal or state authorities, and authorized to transact business in the state of Iowa;

(2) Be in the minimum amount of \$50,000;

(3) Be subject to lawful levy of execution on behalf of any person to whom the adjuster has been found to be legally liable as the result of an adjuster's erroneous act, failure to act, fraud, acts in violation of Iowa Code chapter 522C, or unfair or deceptive act or practice as determined pursuant to Iowa Code chapter 507B; and

(4) Provide written notice of termination to the licensee at least 30 days prior to termination.

**55.10(2)** The division may request evidence of financial responsibility at any time the division deems relevant.

**55.10(3)** An adjuster shall immediately notify the division if evidence of financial responsibility terminates or becomes impaired. The authority to act as an adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

This rule is intended to implement Iowa Code chapter 522C.

[Filed Emergency 5/5/26, effective 5/5/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0296D**

## **RACING AND GAMING COMMISSION[491]**

### **Adopted and Filed Emergency**

#### **Rulemaking related to declaratory orders and contested cases**

The Racing and Gaming Commission hereby adopts new Chapter 2503, "Declaratory Orders—Modifications to Uniform Rules," and new Chapter 2506, "Contested Cases—Modifications to Uniform Rules," Iowa Administrative Code.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted 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, 2026 Iowa Acts, Senate File 2463.

#### *Purpose and Summary*

Iowa Code section 17A.24 provides that if an agency does not have rules in effect covering certain procedural subjects, then the Uniform Rules on Agency Procedure adopted by the Administrative Rules Coordinator apply to the agency. The Administrative Rules Coordinator has adopted uniform administrative rules under agency [7].

2026 Iowa Acts, Senate File 2463, section 4, subsections 1(be) and (bf), legislatively rescind certain Commission rules effective July 1, 2026. Accordingly, under Iowa Code section 17A.24(2), the agency will not have rules in effect addressing the Uniform Rules on Agency Procedure subjects, so the Uniform Rules on Agency Procedure will apply to the Commission. However, under Iowa Code section



17A.24(3), an agency may adopt rules providing for additions, exceptions, or amendments to a uniform rule. Senate File 2463, section 5, authorizes emergency rulemaking for this purpose.

Under Senate File 2463, section 5, subsection 2, an agency may only adopt emergency rules upon making certain findings. The Commission finds that the emergency rules are otherwise necessary under Senate File 2463, section 5, subsection 2(b), as explained below.

Item 1 modifies a uniform rule by streamlining the requirements applicable to intervenors in declaratory order proceedings before the Commission. The uniform rule requires potential intervenors to detail facts supporting the intervenor's standing and qualifications for intervention. The Commission's modification requires potential intervenors only to detail facts supporting the intervenor's qualifications for intervention. This modification is necessary because an intervenor's qualifications for intervention necessarily include the intervenor's standing, rendering a separate mention of standing superfluous.

Item 2 modifies a uniform rule by providing that lengthy and technical filings will not be required in certain categories of licensing appeals. The uniform rule provides that filing requirements in contested cases may be imposed by rule, by the notice of hearing, or by order of the presiding officer. The Commission's modification to this rule adds an exception clarifying that for certain categories of occupational licensing appeals, pleadings other than a notice of appeal will not be required. Adding this language to the rule is necessary because it avoids imposing a potential burden on occupational license applicants, many of whom are not represented by counsel when going through the licensing process.

*Reason for Adoption of Rulemaking Without  
Prior Notice and Opportunity for Public Participation*

Pursuant to Iowa Code section 17A.4(3), the Commission finds that notice and public participation are unnecessary or impractical because statute so provides. 2026 Iowa Acts, Senate File 2463, section 5, authorizes emergency rulemaking to provide for additions, exceptions, or amendments to the Uniform Rules on Agency Procedure.

*Reason for Waiver of Normal Effective Date*

Pursuant to Iowa Code section 17A.5(2)“b”(1)(a), the Commission also finds that the normal effective date of this rulemaking, 35 days after publication, should be waived and the rulemaking made effective on June 30, 2026, because 2026 Iowa Acts, Senate File 2463, section 5, authorizes emergency rulemaking for the purpose stated above.

*Adoption of Rulemaking*

This rulemaking was adopted by the Commission on April 23, 2026.

*Concurrent Publication of Notice of Intended Action*

In addition to its adoption on an emergency basis, this rulemaking has been initiated through the normal rulemaking process and is published herein under Notice of Intended Action as **ARC 0297D** to allow for public comment.

*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.

*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 June 30, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 491—Chapter 2503:

CHAPTER 2503

DECLARATORY ORDERS—MODIFICATIONS TO UNIFORM RULES

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

**491—2503.3(17A) Intervention in declaratory order proceedings.**

**2503.3(3)** An intervenor seeking to intervene in a declaratory order proceeding is obligated to file the petition for intervention with the commission. The petition for intervention is considered filed when received either in hard copy or by email. The commission will provide the intervenor with a file-stamped copy of the petition upon request. The commission will only accept petitions for intervention that are typewritten or legibly handwritten in ink. Intervenors are also obligated to submit the petition so that it substantially conforms with the following:

BEFORE THE IOWA RACING AND GAMING COMMISSION

|                                                                                                                   |                           |
|-------------------------------------------------------------------------------------------------------------------|---------------------------|
| Petition by [name of original petitioner]<br>For a declaratory order regarding<br>[applicable statutes or rules]. | PETITION FOR INTERVENTION |
|-------------------------------------------------------------------------------------------------------------------|---------------------------|

1. Facts supporting the intervenor's qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. Whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by any agency or court of law.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by or interested in the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

ITEM 2. Adopt the following **new** 491—Chapter 2506:

CHAPTER 2506

CONTESTED CASES—MODIFICATIONS TO UNIFORM RULES

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

**491—2506.11(17A) Pleadings in contested cases.**

**2506.11(1) *Filing requirements.*** Filing requirements may be imposed by rule, by the notice of hearing, or by order of the presiding officer. However, pleadings other than a notice of appeal will not be required in appeals from a licensing decision by a gaming representative, gaming board, or board of stewards.

[Filed Emergency 4/28/26, effective 6/30/26]

[Published 5/27/26]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0299D**

**WORKFORCE DEVELOPMENT DEPARTMENT[871]**

**Adopted and Filed Emergency**

**Rulemaking related to contested cases**

The Workforce Development Department hereby adopts new Chapter 2506, “Contested Cases,” Iowa Administrative Code.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 17A.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 17A.

*Purpose and Summary*

This rulemaking modifies the Uniform Rules on Agency Procedure related to contested cases (7—Chapter 2506) to ensure that contested cases arising from Workforce Innovation and Opportunity Act programs, Registered Apprenticeship programs, and Vocational Rehabilitation programs are governed by the applicable federal regulations (20 CFR Part 683, Subpart F; 29 CFR Parts 29 and 30; and 34 CFR Part 361) and not the contested case provisions of 7—Chapter 2506.

The new Uniform Rules on Agency Procedure are effective as of January 13, 2026, which means there is an inconsistency between the contested case provisions of the Uniform Rules on Agency Procedure and the procedures laid out in 20 CFR Part 683, Subpart F; 29 CFR Parts 29 and 30; and 34 CFR Part 361. Earlier adoption of this rulemaking will allow the Department to ensure any contested case coming before the Department has clear direction as to the appropriate procedural requirements.

*Reason for Adoption of Rulemaking Without  
Prior Notice and Opportunity for Public Participation*

Pursuant to Iowa Code section 17A.4(3), the Department finds that notice and public participation are unnecessary or impractical because statute so provides. 2026 Iowa Acts, Senate File 2463, section 5, authorizes emergency rulemaking to provide for additions, exceptions, or amendments to the Uniform Rules on Agency Procedure.

*Reason for Waiver of Normal Effective Date*

Pursuant to Iowa Code section 17A.5(2)“b”(1)(a), the Department also finds that the normal effective date of this rulemaking, 35 days after publication, should be waived and the rulemaking made effective on May 4, 2026, because 2026 Iowa Acts, Senate File 2463, section 5, authorizes emergency rulemaking for the purpose stated above.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on May 4, 2026.

*Concurrent Publication of Notice of Intended Action*

In addition to its adoption on an emergency basis, this rulemaking has been initiated through the normal rulemaking process and is published herein under Notice of Intended Action as **ARC 0298D** to allow for public comment.

*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 7—Chapter 2504.

*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 became effective on May 4, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following new 871—Chapter 2506:

CHAPTER 2506  
CONTESTED CASES

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

**871—2506.1(17A) Scope and applicability.** 7—Chapter 2506 applies to contested case proceedings conducted by the agency, including vendor appeals. However, 7—Chapter 2506 does not apply to the extent that a contested case being addressed by the agency is governed by 20 CFR Part 683, Subpart F, as amended to May 4, 2026; 29 CFR Parts 29 and 30 as amended to May 4, 2026; 34 CFR Part 361 as amended to May 4, 2026; or 871—Chapter 26.

[Filed Emergency 5/4/26, effective 5/4/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

ARC 0309D

**ECONOMIC DEVELOPMENT AUTHORITY[261]****Adopted and Filed****Rulemaking related to Iowa energy center**

The Economic Development Authority hereby rescinds Chapter 403, “Iowa Energy Center,” Iowa Administrative Code, and adopts a new Chapter 403 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code section 15.120.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code section 15.120.

*Purpose and Summary*

Pursuant to Executive Order 10, the Authority is rescinding Chapter 403 and adopting a new chapter in lieu thereof. The chapter describes the organization of the Iowa Energy Center (IEC) and its Board. The IEC is administered by the Authority pursuant to Iowa Code section 15.120.

The proposed chapter omits language that is duplicative of statutory language and other unnecessary or inconsistent language.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on January 7, 2026, as **ARC 9951C**. A public hearing was held on the following date(s):

- January 27, 2026
- January 29, 2026

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 IEC Board on May 5, 2026.

*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.

*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 July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 261—Chapter 403 and adopt the following **new** chapter in lieu thereof:

CHAPTER 403  
IOWA ENERGY CENTER

**261—403.1(15) Definitions.** As used in these rules, unless the context otherwise requires:

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Board*” means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2) and includes the members appointed to the board by the governor.

“*Committee*” means a committee established by the board.

“*Iowa energy center*” or “*IEC*” means the Iowa energy center established pursuant to Iowa Code section 15.120 for the purposes identified therein.

**261—403.2(15) Iowa energy center board.**

**403.2(1) Quorum and voting requirements.** Seven or more members of the board constitute a quorum, and any board action requires an affirmative vote by a majority of the members present.

**403.2(2) Board officers.** Members of the board elect a chairperson and a vice chairperson annually and may elect other officers as necessary.

**403.2(3) Meetings.**

*a.* The board generally meets quarterly at the authority's offices or by electronic means. By notice of the regularly published meeting agendas, the board and its committees may hold regular or special meetings at other locations within the state. Meeting agendas are available on the authority's website at [www.opportunityiowa.gov](http://www.opportunityiowa.gov).

*b.* The chairperson may exclude any person disrupting the proceedings.

**403.2(4) Committees.** The board may, from time to time, establish advisory committees for purposes of overseeing the IEC, its programs, and its operations. Such committees include but are not limited to the following:

*a.* A grant committee is established to assist the board in making and administering awards of grants under the IEC's programs.

(1) The grant committee is an advisory body comprised of voting members of the board who are selected annually by the voting members of the board. The membership and size of the committee as well as the terms of the committee members will be established annually by the board.

(2) The members of the grant committee may elect a chairperson. The chairperson may appoint members of the grant committee to serve on a grant committee subcommittee if necessary. Such a subcommittee is advisory only and may perform such duties as may be assigned by the chairperson.

(3) The duties of the grant committee may include reviewing applications for grant awards, making recommendations to the board regarding the size and condition of grant awards, and any other duty assigned by the board in relation to the programs administered by the IEC.

(4) A majority of the committee members constitutes a quorum of the committee.

(5) Meetings of the grant committee are held at the call of the chairperson.

*b.* A loan committee is established to assist the board in making and administering loan awards under the IEC's programs, including the alternate energy revolving loan program and energy infrastructure revolving loan program.

(1) The loan committee is an advisory body comprised of voting members of the board who are selected annually by the voting members of the board. The membership and size of the committee as well as the terms of the committee members will be established annually by the board.

(2) The members of the loan committee may elect a chairperson. The chairperson may appoint members of the loan committee to serve on a loan committee subcommittee if necessary. Such a subcommittee is advisory only and may perform such duties as may be assigned by the chairperson.

(3) The duties of the loan committee may include reviewing applications for loans, making recommendations to the board regarding the size and condition of loans, and any other duty assigned by the board in relation to the programs administered by the IEC.

(4) A majority of the committee members constitutes a quorum of the committee.

(5) Meetings of the loan committee are held at the call of the chairperson.

These rules are intended to implement Iowa Code section 15.120.

[Filed 5/6/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0310D**

## **ECONOMIC DEVELOPMENT AUTHORITY[261]**

### **Adopted and Filed**

#### **Rulemaking related to alternate energy revolving loan program**

The Economic Development Authority hereby rescinds Chapter 405, "Alternate Energy Revolving Loan Program," Iowa Administrative Code, and adopts a new Chapter 405 with the same title.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code sections 15.120 and 476.46.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code section 476.46.

#### *Purpose and Summary*

Pursuant to Executive Order 10, the Authority is rescinding Chapter 405 and adopting a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Alternate Energy Revolving Loan Program. The Program encouraged the development of alternate energy production facilities and small hydro facilities within the State. New applications for loans ceased as of June 30, 2021, pursuant to 2021 Iowa Acts, Senate File 619, but the chapter continues to apply to outstanding loans. The updated chapter is clearer and more concise throughout and omits language relating to the approval of new loans.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on January 7, 2026, as **ARC 9950C**. A public hearing was held on the following date(s):

- January 27, 2026
- January 29, 2026

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 Iowa Energy Center Board on May 5, 2026.

*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.

*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 July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 261—Chapter 405 and adopt the following **new** chapter in lieu thereof:

## CHAPTER 405

## ALTERNATE ENERGY REVOLVING LOAN PROGRAM

**261—405.1(15) Definitions.**

*“Alternate energy production facility”* means the same as defined in Iowa Code section 476.42.

*“Authority”* means the economic development authority created in Iowa Code section 15.105.

*“Board”* means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2).

*“Iowa energy center”* or *“IEC”* means the Iowa energy center established by Iowa Code section 15.120.

*“Project”* means the construction of an alternate energy production facility or a small hydro facility.

*“Small hydro facility”* means the same as defined in Iowa Code section 476.42.

**261—405.2(15) Loan amounts and terms.**

**405.2(1)** The minimum loan amount is \$25,000 per project, and the maximum loan amount shall not exceed the amount set forth in Iowa Code section 476.46(2) “d.”

**405.2(2)** The board shall not lend more than 50 percent of eligible project costs.

**405.2(3)** Loan terms will be consistent with Iowa Code section 476.46(2) “e.”

**405.2(4)** A borrower shall be eligible for not more than \$1 million in loans outstanding at any time under this program.

**405.2(5)** The board shall not issue a loan that exceeds the value of the collateral provided.

**405.2(6)** The board will accept security for a loan. The following forms of collateral will be accepted:

- a. Real property;
- b. Dedicated certificate of deposit;
- c. Irrevocable letter of credit;
- d. Corporate guarantee;
- e. Other forms of collateral if approved by the board and only if the forms of collateral listed in paragraphs 405.2(6) “a” through “d” are inadequate.

**405.2(7) Term.** The duration of the loan shall be for 20 years, the estimated useful life of the project that is financed by the loan, the terms of any other loans used to finance the project, or the estimated return on investment time period for the project, whichever is shortest.

**261—405.3(15) Borrowers.**

**405.3(1) Eligible borrowers.** The project shall be wholly owned by an eligible borrower. Eligible borrowers include:

- a. Persons whose primary residence is in Iowa.
- b. Businesses registered and domiciled in Iowa. For businesses organized as limited liability companies, each member of the limited liability company must be domiciled in Iowa and be an eligible borrower.
- c. Water and wastewater utilities subject to Iowa Code chapter 388, rural water districts subject to Iowa Code chapters 357A and 504, and sanitary districts subject to Iowa Code chapter 358.

**405.3(2) Ineligible borrowers.** Ineligible borrowers include:

- a. An organization that is lending to a project and also owns the project or is a member of an organization that owns the project.
- b. An individual or an organization with a history of defaulted loans or compliance violations with other state programs or rules.
- c. Regents institutions.
- d. Community colleges.
- e. State agencies.
- f. Cities, but not water or wastewater utilities subject to Iowa Code chapter 388.
- g. Counties.
- h. School districts.
- i. Nonprofit organizations.
- j. Gas and electric utilities subject to Iowa Code chapter 388 or rural electric cooperatives subject to Iowa Code chapter 476.

**261—405.4(15) Administration.**

**405.4(1) Amendment.** Any substantive change to a project shall require an amendment to the loan agreement. The borrower shall request the amendment in writing. No substantive amendment shall be valid until approved by the board. The authority may execute nonsubstantive or corrective changes to the loan agreement without board approval.

**405.4(2) Closeout.** Upon project completion, the authority will initiate project closeout procedures.

**405.4(3) Recordkeeping and retention.** Borrowers shall retain all financial records, all supporting documents, and all other records pertinent to the loan for five years after the loan agreement is closed or the date the authority issues a written notice of default if the default is not cured.

**405.4(4) Reporting and compliance.** The authority reserves the right to conduct a site visit of all awarded projects to ensure the projects were built as proposed and to provide verification of ongoing operation. The authority will monitor all loans to ensure that loan proceeds have been spent as identified in the contract and that all other sources of financing have been committed to the project. Borrowers shall be required to notify the authority of any change in ownership.

**405.4(5) Default.**

- a. At any time during the construction of a project or the repayment of the loan, the authority may find that a borrower is in default under the terms of the loan agreement. The authority will take prompt, appropriate, and aggressive debt collection action to recover any funds misspent by borrowers.

b. If the authority determines that a borrower is in default, the authority may seek recovery of the loan plus interest or other penalties as authorized pursuant to Iowa Code section 476.46, negotiate alternative payment schedules, suspend or discontinue collection efforts, and take other action as the authority deems necessary.

c. The authority shall attempt to collect the amount owed. Any negotiated settlement, write-off, or discontinuance of collection efforts is subject to final review by and approval of the board.

d. If the authority refers a defaulted loan to outside counsel for debt collection, then the terms of the contract between the authority and the outside counsel regarding the scope of counsel's authorization to accept settlements shall apply.

**261—405.5(15) Applicability after June 30, 2021.** To the extent allowed by other provisions of law, the rules adopted in this chapter shall continue to apply to agreements entered into on or before June 30, 2021.

These rules are intended to implement Iowa Code sections 15.120 and 476.46.

[Filed 5/6/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0311D**

## **ECONOMIC DEVELOPMENT AUTHORITY[261]**

### **Adopted and Filed**

#### **Rulemaking related to energy infrastructure revolving loan program**

The Economic Development Authority hereby rescinds Chapter 406, "Energy Infrastructure Revolving Loan Program," Iowa Administrative Code, and adopts a new Chapter 406 with the same title.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code sections 15.120 and 476.46A.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code section 476.46A.

#### *Purpose and Summary*

Pursuant to Executive Order 10, the Authority is rescinding Chapter 406 and adopting a new chapter in lieu thereof. The chapter describes the policies and procedures applicable to the Energy Infrastructure Revolving Loan Program. The program provides loans for the development and construction of energy infrastructure. The updated chapter will be clearer and more concise throughout. Rule 261—406.6(15,476) currently lists feasibility studies, engineering, and final design as ineligible costs. The new rule regarding eligible and ineligible costs (261—406.5(15,476)) does not list those items as ineligible costs since they may be included as project costs under certain circumstances.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on January 7, 2026, as **ARC 9949C**. A public hearing was held on the following date(s):

- January 27, 2026
- January 29, 2026

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 Iowa Energy Center Board on May 5, 2026.

*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.

*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 July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 261—Chapter 406 and adopt the following **new** chapter in lieu thereof:

CHAPTER 406  
ENERGY INFRASTRUCTURE REVOLVING LOAN PROGRAM

**261—406.1(15,476) Definitions.**

“*Affiliates*” means any entity that directly or indirectly, through one or more intermediaries controls, is controlled by, or is under common control with another entity or person. “Control” as used in this definition means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. A voting interest of 10 percent or more creates a rebuttable presumption of control.

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Board*” means the governing board of the Iowa energy center established pursuant to Iowa Code section 15.120(2).

“*Borrower*” means an applicant for the program that is approved for a loan.

“*Energy infrastructure*” means the same as defined in Iowa Code section 476.46A(3) “a.”

“*Iowa energy center*” or “*IEC*” means the Iowa energy center established by Iowa Code section 15.120.

“*Loan*” means an award of assistance with the requirement that the award be repaid with term, interest rate, and other conditions specified as part of the conditions of the award.

“*Loan committee*” means the committee of the board established to review loan applications pursuant to 261—Chapter 403.

“*Program*” means the energy infrastructure revolving loan program administered pursuant to Iowa Code section 476.46A and this chapter.

“*Project*” means an activity or set of activities, proposed in an application by a borrower, that are designed to accomplish the energy infrastructure goals of the program.

**261—406.2(15,476) Loan amounts and terms.**

**406.2(1)** The minimum loan amount is \$50,000 per project.

**406.2(2)** The board shall not lend more than 75 percent of total project costs for any project type. For purposes of determining the amount the board may lend pursuant to this subrule, total project costs include eligible costs pursuant to subrule 406.5(1) as well as other costs determined by the board to be necessary to the development of energy infrastructure.

**406.2(3)** The board shall not issue a loan that exceeds the value of the collateral provided.

**406.2(4)** The board will accept security for a loan. The following forms of collateral will be accepted:

- a.* Real property.
- b.* Dedicated certificate of deposit.
- c.* Irrevocable letter of credit.
- d.* Corporate guarantee.
- e.* Utility revenue or reserve funds, if applicable.
- f.* Other forms of collateral if approved by the board and only if the forms of collateral listed in paragraphs 406.2(4)“*a*” through “*e*” are inadequate.

**406.2(5)** The board may consider the borrower’s credit rating in determining what form of collateral is acceptable.

**406.2(6)** The board may consider the projected payback date of the project in determining the duration of the loan, which shall not exceed 15 years.

**406.2(7)** The interest rate shall not exceed the Wall Street Journal prime rate as of the date of approval.

**261—406.3(15,476) Eligible and ineligible borrowers.**

**406.3(1)** *Eligible borrowers.* Iowa Code section 476.46A(2) describes the entities eligible for financial assistance under this program.

**406.3(2)** *Ineligible borrowers.* Ineligible borrowers include:

- a.* A business that is not located in or operating in Iowa. A business that will be located and operating in Iowa upon completion of an eligible project may be eligible.
- b.* An individual or an organization with a history of defaulted loans or compliance violations with other state programs or rules.
- c.* Regents institutions.
- d.* Community colleges.
- e.* State agencies.
- f.* Cities, except municipal utilities that are eligible borrowers pursuant to Iowa Code section 476.46A(2).
- g.* Counties.
- h.* School districts.
- i.* Nonprofit organizations.

**261—406.4(15,476) Eligible and ineligible projects.**

**406.4(1)** Only projects meeting the following criteria are eligible for a loan under this program:

*a.* The project shall be located in Iowa or be for the primary use or benefit of Iowans. If any portion of the project is located outside of Iowa, the applicant bears the burden of demonstrating that the project as a whole will be for the primary use or benefit of Iowans.

*b.* The project shall develop and construct energy infrastructure pursuant to Iowa Code section 476.46A(3)“*a.*”

c. The borrower shall be the owner, contract purchaser, lessee, or other interest holder of the real property where the project is located.

**406.4(2)** A project that generates energy for use only at a borrower's personal residence is not an eligible project.

**261—406.5(15,476) Eligible and ineligible costs.**

**406.5(1)** *Eligible costs.* Examples of project costs that are eligible for financial assistance include but are not limited to:

- a. Real and personal property comprising a project.
- b. Materials and equipment required for necessary site preparation, construction, and installation.
- c. Labor for site preparation, construction, and installation of a project.
- d. Costs associated with maintenance, operation, or repair of a project during the term of the loan.

**406.5(2)** *Ineligible costs.* Examples of project costs that are not eligible for financial assistance include but are not limited to:

- a. Administrative costs or employee salaries of the borrower or any affiliates that are not associated with site preparation, construction, and installation of a project.
- b. Costs incurred prior to the committee's recommendation to approve a loan. Costs incurred prior to the committee's recommendation may be eligible for assistance if the borrower demonstrates the necessity to begin incurring costs sooner.
- c. Permitting or regulatory costs.
- d. Other costs that the board determines to be ineligible.

**261—406.6(15,476) Application process.**

**406.6(1)** Application forms are available at [iowagrants.gov](http://iowagrants.gov).

**406.6(2)** Applications will be accepted only during the established application periods identified by the authority on its website at [www.opportunityiowa.gov](http://www.opportunityiowa.gov).

**406.6(3)** The authority will review applications for completeness, eligibility, and technical and financial merit. The authority may engage outside reviewers to complete technical, financial, or other reviews of applications as needed. The authority may request additional information from applicants to complete review of applications.

**406.6(4)** The authority will prepare recommendations for the loan committee. The loan committee will review the applications and staff recommendations and then make recommendations to the board. The board will approve, defer, or deny applications for loans. The authority may negotiate the amount, terms, and other conditions of each loan before an award is approved.

**261—406.7(15,476) Administration.**

**406.7(1)** *Notice of approval or denial.* The authority will notify applicants in writing of the board's approval or denial of an application. If the application is approved, the notice will include any conditions and terms of the loan.

**406.7(2)** *Loan agreement.* A borrower shall enter into a loan agreement with the authority. The borrower will execute and return the loan agreement to the authority within 90 days of the transmittal of the final loan agreement from the authority. Failure to do so may be cause for the board to terminate the award.

**406.7(3)** *Disbursement of funds.* Borrowers shall submit requests for disbursement of funds in the manner proscribed by the authority.

**406.7(4)** *Amendment.* Any substantive change to the scope of work for a project or request to renegotiate loan terms shall require an amendment to the loan agreement. The borrower shall request amendments in writing. No substantive amendment shall be valid until approved by the board. The authority may execute nonsubstantive or ministerial changes to the loan agreement without board approval.

**406.7(5)** *Loan forgiveness.* The board may consider requests for loan forgiveness if the borrower demonstrates forgiveness is necessary to avoid a negative material impact on the project or potential default.

**406.7(6)** *Closeout.* Upon project completion, the authority will initiate project closeout procedures.

**406.7(7)** *Recordkeeping and retention.* Borrowers shall retain all financial records, all supporting documents, and all other records pertinent to the loan for five years after the loan agreement is closed or the date the authority issues a written notice of default if the default is not cured.

**406.7(8)** *Reporting and compliance.* The borrower shall complete all reports required by the loan agreement. The borrower 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. The authority reserves the right to conduct site visits of all awarded projects to ensure the projects were built as proposed and to provide verification of ongoing operation. The authority will monitor all loans to ensure that loan proceeds have been spent as identified in the loan agreement and that all other sources of financing have been committed to the project.

**406.7(9)** *Default.*

*a.* At any time during the project or the repayment of the loan, the authority may find that a borrower is in default under the terms of the loan agreement. The authority will take prompt, appropriate, and aggressive debt collection action to recover any funds misspent by borrowers.

*b.* If the authority determines that a borrower is in default, the authority may seek recovery of the loan plus interest or other penalties, negotiate alternative payment schedules, suspend or discontinue collection efforts, and take other action as the authority deems necessary.

*c.* The authority shall attempt to collect the amount owed. Any negotiated settlement, write-off, or discontinuance of collection efforts is subject to final review by and approval of the board.

*d.* If the authority refers a defaulted loan to outside counsel for debt collection, then the terms of the contract between the authority and the outside counsel regarding the scope of counsel's authorization to accept settlements shall apply.

These rules are intended to implement Iowa Code sections 15.120 and 476.46A.

[Filed 5/6/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0312D**

## **HUMAN SERVICES DEPARTMENT[441]**

### **Adopted and Filed**

#### **Rulemaking related to managed care**

The Department of Health and Human Services hereby rescinds Chapter 73, "Managed Care," Iowa Administrative Code, and adopts a new Chapter 73 with the same title.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 249A.

#### *Purpose and Summary*

This chapter underwent 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. This chapter provides that most Iowa Medical Assistance Program benefits will be provided through managed care.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9853C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings. No public comments were received.

Changes from the Notice have been made. First, the Department has restored clarifying language to the definition of “managed care plan” to indicate that managed care plans establish the conditions, procedures, and payment rates or methodologies to be consistent with this chapter and with the contract between the Department and the managed care plan. The language had previously been in the chapter’s preamble, which was deleted during the Red Tape Review as being redundant.

The Department also updated references from 441—Chapter 7 to 441—Chapter 2506 to reflect the Department’s contested case chapter as modified pursuant to the new Uniform Rules on Agency Procedure, which go into effect July 1, 2026.

Finally, the Department changed a term from “physician assistant” to “physician associate,” commensurate with 2026 Iowa Acts, Senate File 2190.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

*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 2504.

*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 July 1, 2026.

The following rulemaking action is adopted:

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 of 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. The benefits provided through managed care will be paid for by the MCP participating in the programs pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the MCP, consistent with this chapter and with the contract between the department and the MCP.

*"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 rule 441—75.8(249A).
- 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 HIPD 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 associates, 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 2506 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 2506; 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:

- Ninety percent of all clean claims within 14 calendar days of receipt,
- Ninety-nine percent of all clean claims within 90 calendar days of receipt, and
- 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.

[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0313D****HUMAN SERVICES DEPARTMENT[441]****Adopted and Filed****Rulemaking related to the Iowa health and wellness plan**

The Department of Health and Human Services hereby rescinds Chapter 74, “Iowa Health and Wellness Plan,” Iowa Administrative Code, and adopts a new Chapter 74 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is adopted 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 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 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 changed the due date for financial participation payments from the last day of the month to the fifteenth day of the month.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9848C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings. No public comments were received.

Changes from the Notice have been made. The Department restored language in subrules 74.5(1) and 74.5(3) regarding the enrollment period that had inadvertently been deleted. The Department also updated subrule 74.10(1) to reference 441—Chapter 2506 instead of 441—Chapter 7.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

*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 2504.

*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 July 1, 2026.

The following rulemaking action is adopted:

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. The enrollment period will continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,249N).

**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 of 12 consecutive months will not apply to individuals temporarily enrolled in Medicaid 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 2506.

**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 a program for all-inclusive care for the elderly (PACE), 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.

[Filed 5/5/26, effective 7/1/26]

[Published 5/27/26]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0314D**

## **HUMAN SERVICES DEPARTMENT[441]**

### **Adopted and Filed**

#### **Rulemaking related to conditions of participation for providers of medical and remedial care**

The Department of Health and Human Services hereby rescinds Chapter 77, “Conditions of Participation for Providers of Medical and Remedial Care,” Iowa Administrative Code, and adopts a new Chapter 77 with the same title.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 249A.

#### *Purpose and Summary*

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

This 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, reorganized the chapter, and standardized the use of acronyms.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9855C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings.

One public comment was received. A provider of brain injury services requested that the Department clarify and expand the scope of other nationally recognized brain injury certifications to explicitly include tiered certification programs designed for direct support professionals. The Department did not make any changes in response to this request since it had been previously determined by the Brain Injury Advisory Committee that the training programs in question did not meet their needs.

The following changes from the Notice have been made:

- Updated references to the Supports Intensity Scale® (SIS) assessment tool to the interRAI assessment tool throughout. Use of the SIS assessment tool sunsetted on December 31, 2025.
- Updated “physician assistant” to “physician associate” throughout pursuant to 2026 Iowa Acts, Senate File 2190.
- Updated references from 441—Chapter 7 to 441—Chapter 2506 to reflect the new Uniform Rules on Agency Procedure that go into effect July 1, 2026.

#### *Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

#### *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 2504.

#### *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 July 1, 2026.

The following rulemaking action is adopted:

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 (AAAHHC), or
6. The Department, pursuant to 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 dental board 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 associates.** All physician associates licensed to practice in the state of Iowa are eligible for participation in the program. Physician associates 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](http://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 home-based habilitation services.

(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 (CQL).

(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 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 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 COA.
- (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 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 analyst certification 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 and the HCBS provider manual as amended to July 1, 2026.

**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 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 service providers meeting the standards set forth in subrule 77.35(1).

**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.

**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 service providers.*** Homemaker service providers meeting the criteria in subrule 77.35(1) are eligible to participate.

**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 rules in 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 rules in 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 this rule 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) Agencies certified by the department to provide residential-based supported community living services. Residential-based supported community living service providers shall 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 interRAI assessment tool 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 interRAI assessment tool 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 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 2506.

(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 associates.*** A physician associate 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 (the Council), or 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 2506.

**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 service provider organizations are eligible to participate in the Medicaid HCBS BI waiver program provided the case management service provider organizations meet the standards in 441—Chapter 24 and the case management service 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 rules in 441—Chapters 108, 112, and 114 through 116.

c. Providers of services 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 services 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 whose owner or renter 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, the positive behavioral support and consultation providers 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—paragraph 75.6(5)“a”.

**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.

[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0315D**

**HUMAN SERVICES DEPARTMENT[441]**

**Adopted and Filed**

**Rulemaking related to medical and remedial services**

The Department of Health and Human Services hereby rescinds Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” Iowa Administrative Code, and adopts a new Chapter 78 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 249A.

*Purpose and Summary*

This chapter outlines parameters for provision and payment for services under Iowa Medicaid. The chapter provides guidance to participating providers and members about which services are covered, are not covered, and require prior authorization.

This rulemaking was 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 sunseting, 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.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9865C**. Public hearings were held on the following date:

- January 13, 2026

The Department received multiple public comments regarding the revisions to numbered paragraph 78.19(1)“a”(6)“3.”

The Department is not making any changes as a result of those comments. 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.

The Department also received public comments regarding the removal of the language specifying the unit cap for supported community living services under the brain injury and intellectual disability waivers. The Department had instead proposed to refer individuals to the fee schedule on the Department’s website for those unit caps. That language has been restored to that of the existing rules.

The Department also made the following changes from the Notice:

- Updated “physician assistant” to “physician associate” throughout pursuant to 2026 Iowa Acts, Senate File 2190.
- Restored detailed language to rule 441—78.4(249A) regarding dental services that are payable, are excluded, or require prior approval rather than referring to a provider manual.
- Restored eligibility language from the existing rules relating to risk factors and need for assistance in subrule 78.27(2) rather than referring to a provider manual for that information.
- Restored language from the existing rules regarding eligibility for home-based habilitation services in subrule 78.27(7) rather than referring to a provider manual for that information.
- Added references to advanced registered nurse practitioners and physician associates in numbered paragraph 78.31(4)“c”(2)“1” to reflect the fact that CMS allows these provider types to act as supervising physicians in cardiac rehabilitation clinics.

- Removed erroneously placed language regarding case management from subrule 78.34(3), which describes adult day care services.
- Updated an erroneous cross-reference in subparagraph 78.41(1)“i”(2).
- Added back inadvertently deleted language regarding respite care to rule 441—78.43(249A) and renumbered.
- Updated an incorrect cross-reference in subrule 78.46(4) regarding specialized medical equipment.
- Updated references to 441—Chapter 7 to instead refer to 441—Chapter 2506 to reflect the Department’s new contested case chapter pursuant to the new Uniform Rules on Agency Procedure that become effective July 1, 2026.
- Removed a reference to 2025 Iowa Acts, House File 1049, since that legislation has been codified.

#### *Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

#### *Fiscal Impact*

Based on a review of State fiscal year 2025 data, the estimated annualized savings from the updated language of numbered paragraph 78.19(1)“a”(6)“3” would be \$2.8 million for the State.

#### *Jobs Impact*

The Department has received feedback that the revisions to numbered paragraph 78.19(1)“a”(6)“3” will potentially impact some businesses, including jobs.

#### *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 7—Chapter 2504.

#### *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 July 1, 2026.

The following rulemaking action is adopted:

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 associate (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.
- (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) Facelifts 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) as amended to July 1, 2026. 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](http://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, and immunosuppressive 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. Psychosocial.

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 2506.

**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. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures.

**78.4(1) Preventive services.** Payment will be made for the following preventive services:

*a.* Oral prophylaxis, including necessary scaling and polishing, once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

*b.* Topical application of fluoride, once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

*c.* Pit and fissure sealants for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion, or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

**78.4(2) Diagnostic services.** Payment will be made for the following diagnostic services:

a. A comprehensive oral evaluation once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panographic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bite-wing films only once in a 12-month period.

e. Single periapical films when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts only for orthodontic cases or dental implants or when requested by Iowa Medicaid.

l. Cone beam images when medically necessary for situations including but not limited to detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

**78.4(3) Restorative services.** Payment will be made for the following restorative services:

a. Treatment of dental caries in those areas that require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials only once for the same restoration in a two-year period.

c. Crowns when there is at least a fair prognosis for maintaining the tooth as determined by Iowa Medicaid and when a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval will be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or when there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval will be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

d. Cast post and core, post and composite or post and amalgam in addition to a crown when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

e. The following restoration procedures, as indicated:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth will be paid as a one-surface restoration (i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid).

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(5) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(6) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(7) More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.

(8) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

**78.4(4) Periodontal services.** Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing once every 24 months when prior approval has been received. Prior approval will be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

c. Periodontal surgical procedures including gingivoplasty, osseous surgery, and osseous allograft when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft with prior approval. Authorization will be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene.

e. Periodontal maintenance therapy, which requires prior authorization. Approval will be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

f. Tissue regeneration procedures, which require prior authorization. Approval will be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents, which requires prior authorization. Approval will be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

**78.4(5) Endodontic services.** Payment will be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue when nonsurgical treatment has been attempted and

a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment, including gross underfilling, perforations, and canal blockages with restorative materials.

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment will be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

**78.4(6) Oral surgery—medically necessary.** Payment will be made for medically necessary oral surgery services furnished by dentists to the extent that these services may 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 as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

- a. Extractions, both surgical and nonsurgical.
- b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.
- c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.
- d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.
- e. Root recovery (surgical removal of residual root).
- f. Oral antral fistula closure (or antral root recovery).
- g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.
- h. Surgical exposure of impacted or unerupted tooth to aid eruption.
- i. Postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

**78.4(7) Prosthetic services.** Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval will be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval will be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture.

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval will be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval will be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period.

j. Adjustments to a complete or removable partial denture when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization will be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period, which requires prior authorization. Approval will be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval will also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase, which requires prior approval. Approval will be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea, which requires prior approval and must be custom-fabricated. Approval will be granted in accordance with Medicare criteria.

**78.4(8)** *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval will be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval will be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and will be granted when the member has a severe handicapping malocclusion as defined by the department and when determined to be medically necessary.

**78.4(9)** *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. Payment will not be made for writing prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment that warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval will be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

**78.4(10)** *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

**78.4(11)** *Emergency services.* Payment will be made for emergency services as defined in and pursuant to the requirements set forth in 42 CFR 438.114 as amended to July 1, 2026.

**78.4(12)** *Prior authorization.* Certain dental services require prior authorization as set forth in this rule. Covered dental service categories requiring prior approval are further defined and outlined in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

**78.4(13)** *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(14)** *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(15)** *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 Provider Manual as amended to July 1, 2026, 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 2506 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 2506, 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 (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](https://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 at least one of the following risk-based criteria:

(1) The member has a history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the member’s life; or

(2) The member has a history of continuous professional psychiatric supportive care other than hospitalization; or

(3) The member has a history of involvement with the criminal justice system; or

(4) Services available in the member’s community have not been able to meet the member’s needs; or

(5) The member has a history of unemployment or employment in a sheltered setting or poor work history; or

- (6) The member has a history of homelessness or is at risk of homelessness.
- c. Need for assistance.* The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least 12 months:
  - (1) The member needs assistance to obtain or maintain employment.
  - (2) The member requires financial assistance to reside independently in the community.
  - (3) The member needs significant assistance to establish or maintain a personal social support system.
  - (4) The member needs assistance with at least one of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.
  - (5) The member needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual or others.
- 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 LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

2. The member is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

*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 2506. 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 79.10(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 78.31(2)“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 78.31(4) "b"(4).
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, ARNP, or PA responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician, ARNP, or PA 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 dysrhythmia 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, dysrhythmia 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.*

*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 79.10(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) "i"(1) does not apply.

j. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year, except a leap year, when 366 daily units are available.

(2) 20,440 15-minute units per state fiscal year, except a leap year, when 20,496 15-minute units are available.

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(11) "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 by the provider within the member's home and community according to the individualized member need as identified in the service plan.

a. The basic components of the service may include but are not limited to personal and 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 that 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 that 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 those 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 which 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 living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall 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.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and that are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in 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. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, 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, the total costs shall not exceed \$1,570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit 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 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

**78.43(3) 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 care cannot be provided to a member whose usual caregiver is an attendant care 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, supported community living services, nursing, or home health aide services provided through the medical assistance program.

**78.43(4)** *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

**78.43(5)** *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

**78.43(6)** *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(7)** *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(8)** *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(9)** *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

**78.43(10)** *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 regimens 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(11) *Prevocational services.*** Prevocational services are service activities provided pursuant to subrule 78.27(9).

**78.43(12) *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.

**78.43(13) *Attendant care service.*** Attendant care services are service activities performed pursuant to subrule 78.34(7).

**78.43(14) *IMMT services.*** IMMT services are activities performed pursuant to subrule 78.34(8).

**78.43(15) *CCO.*** The CCO is service activities provided pursuant to subrule 78.34(13).

**78.43(16) *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.

[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0316D**

**HUMAN SERVICES DEPARTMENT[441]**

**Adopted and Filed**

**Rulemaking related to providers of medical and remedial care**

The Department of Health and Human Services hereby rescinds Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code, and adopts a new Chapter 79 with the same title.

*Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

*State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapters 124 and 249A and Public Laws 111.5 and 109-177.

### *Purpose and Summary*

This 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 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.

### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9852C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings.

One public comment was received. A provider of air ambulance services requested an increase in reimbursement. This is not something the Department can exclusively do with an amendment to administrative rules. An increase in provider reimbursement would require an appropriation. Additionally, the Department notes that 2024 Iowa Acts, House File 2698, section 14, appropriated \$250,000 to this provider, an 83.4 percent increase in reimbursement.

The Department made the following changes from the Notice:

- Updated the upper limits for payment for Medicaid waiver services in the table in subrule 79.1(2). Those limits now reflect the most recent updates.
- Updated references in subrule 79.1(30) from the Supports Intensity Scale® (SIS) core standardized assessment, which sunsetted on December 31, 2025, to the InterRAI assessment tool, which is the new tool used to assess acuity.
- Removed paragraph 79.1(30)“i” since it is obsolete.
- Updated references to 441—Chapter 7 to 441—Chapter 2506 to reflect the Department's contested case chapter resulting from opt-outs to the new Uniform Rules on Agency Procedure, which become effective July 1, 2026.
- Updated an erroneous cross-reference in subrule 79.7(2).

### *Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

### *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 2504.

*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 July 1, 2026.

The following rulemaking action is adopted:

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—77.47(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.**

| <u>Provider category</u>                                                 | <u>Basis of reimbursement</u>                                 | <u>Upper limit</u>                                                                                                                                         |
|--------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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%<br>Air ambulance: Fee schedule in effect 7/1/21                                                  |
| Ambulatory surgical centers                                              | Base rate fee schedule as determined by Medicare. See 79.1(3) | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Applied behavior analysis                                                | Fee schedule                                                  | Fee schedule in effect 7/1/22                                                                                                                              |
| Area education agencies                                                  | Fee schedule                                                  | Fee schedule in effect 6/30/00 plus 0.7%                                                                                                                   |
| Assertive community treatment                                            | Fee schedule                                                  | Fee schedule in effect 7/1/19. Maximum of 5 days per week                                                                                                  |
| Audiologists                                                             | Fee schedule                                                  | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Behavioral health intervention                                           | Fee schedule                                                  | Fee schedule in effect 7/1/22                                                                                                                              |
| Behavioral health services                                               | Fee schedule                                                  | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Birth centers                                                            | Fee schedule                                                  | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Child care medical services                                              | Fee schedule                                                  | Fee schedule in effect 1/1/16                                                                                                                              |
| Chiropractors                                                            | Fee schedule                                                  | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Clinics                                                                  | Fee schedule                                                  | Maximum physician reimbursement rate                                                                                                                       |
| Community-based neurobehavioral rehabilitation services                  | Fee schedule. See 79.1(28)                                    | Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit |
| Community mental health centers                                          | Retrospective cost-related. See 79.1(25)                      | 100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles                                                                   |
| Crisis response services                                                 | Fee schedule                                                  | Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services                                                          |
| Crisis stabilization community-based services                            | Fee schedule                                                  | Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services                                                          |
| Crisis stabilization residential services                                | Fee schedule                                                  | Fee schedule in effect 2/1/18                                                                                                                              |
| Dentists                                                                 | Fee schedule                                                  | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Drug and alcohol services                                                | Fee schedule                                                  | Fee schedule in effect 1/1/16                                                                                                                              |
| Durable medical equipment, prosthetic devices and medical supply dealers | Fee schedule. See 79.1(4)                                     | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Emergency psychiatric services                                           | Fee schedule                                                  | Fee schedule in effect 1/1/16                                                                                                                              |
| Family planning clinics                                                  | Fee schedule                                                  | Fee schedule in effect 6/30/13 plus 1%                                                                                                                     |
| Federally qualified health centers                                       | Retrospective cost-related. See 441—Chapter 73                | 1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP                                                                               |

| <u>Provider category</u>                  | <u>Basis of reimbursement</u>                                                                                     | <u>Upper limit</u>                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                           |                                                                                                                   | 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:<br>Fee schedule                           | Effective 7/1/24, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/24 rate: Veterans Administration contract rate or \$1.64 per 15-minute unit, \$26.37 per half day, \$52.51 per full day, or \$78.73 per extended day if no Veterans Administration contract |
|                                           | For intellectual disability waiver:<br>Fee schedule for the member's acuity tier, determined pursuant to 79.1(30) | Effective 7/1/24, for intellectual disability waiver: The provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute or half-day rate. If no 6/30/24 rate, \$2.21 per 15-minute unit or \$35.14 per half day.<br>For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30)               |
| 2. Emergency response system:             |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Personal response system                  | Fee schedule                                                                                                      | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: Initial one-time fee: \$58.48. Ongoing monthly fee: \$45.48                                                                                                                                                                                                                                                                    |
| Portable locator system                   | Fee schedule                                                                                                      | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: Initial one-time fee: \$58.48. Ongoing monthly fee: \$45.48                                                                                                                                                                                                                                                                    |
| 3. Home health aides                      | Fee schedule                                                                                                      | For AIDS/HIV, elderly, and health and disability waivers effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1% or maximum Medicaid rate in effect 6/30/24 plus 4.1%                                                                                                                                                                                                                       |
|                                           |                                                                                                                   | For intellectual disability waiver effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1% or maximum Medicaid rate in effect 6/30/24 plus 4.1%, converted to an hourly rate                                                                                                                                                                                                                |
| 4. Homemakers                             | Fee schedule                                                                                                      | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$5.84 per 15-minute unit                                                                                                                                                                                                                                                                       |

| <u>Provider category</u>          | <u>Basis of reimbursement</u> | <u>Upper limit</u>                                                                                                                                                                                                                                                                                                                |
|-----------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5. Nursing care                   | Fee schedule                  | For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: \$98.87 per visit                                                                                                                                              |
| 6. Respite care when provided by: |                               |                                                                                                                                                                                                                                                                                                                                   |
| Home health agency:               |                               |                                                                                                                                                                                                                                                                                                                                   |
| Specialized respite               | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: Lesser of maximum Medicare rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, or maximum Medicaid rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, not to exceed \$356.93 per day |
| Basic individual respite          | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: Lesser of maximum Medicare rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, or maximum Medicaid rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, not to exceed \$356.93 per day |
| Group respite                     | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day                                                                                                                                                       |
| Home care agency:                 |                               |                                                                                                                                                                                                                                                                                                                                   |
| Specialized respite               | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$10.15 per 15-minute unit, not to exceed \$356.93 per day                                                                                                                                                      |
| Basic individual respite          | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$5.41 per 15-minute unit, not to exceed \$356.93 per day                                                                                                                                                       |
| Group respite                     | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day                                                                                                                                                       |
| Nonfacility care:                 |                               |                                                                                                                                                                                                                                                                                                                                   |
| Specialized respite               | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$10.15 per 15-minute unit, not to exceed \$356.73 per day                                                                                                                                                      |
| Basic individual respite          | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/22 rate: \$5.41 per 15-minute unit, not to exceed \$356.93 per day                                                                                                                                                       |
| Group respite                     | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day                                                                                                                                                       |
| Facility care:                    |                               |                                                                                                                                                                                                                                                                                                                                   |

| <u>Provider category</u>                                                | <u>Basis of reimbursement</u> | <u>Upper limit</u>                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hospital or nursing facility providing skilled care                     | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day                                                        |
| Nursing facility                                                        | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day                                                        |
| Camps                                                                   | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93 per day                                                        |
| Adult day care                                                          | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93                                                                |
| Intermediate care facility for persons with an intellectual disability  | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93                                                                |
| Residential care facilities for persons with an intellectual disability | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93                                                                |
| Foster group care                                                       | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93                                                                |
| Child care facilities                                                   | Fee schedule                  | Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.94 per 15-minute unit, not to exceed \$356.93                                                                |
| 7. Chore service                                                        | Fee schedule                  | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$5.84 per 15-minute unit                                                                                        |
| 8. Home-delivered meals                                                 | Fee schedule                  | \$9.11 per meal. Home-delivered liquid supplement meals are two cans per meal.                                                                                                                                                     |
| 9. Home and vehicle modification                                        | Fee schedule. See 79.1(17)    | For elderly waiver: \$1,192.44 lifetime maximum<br><br>For intellectual disability waiver: \$5,962.19 lifetime maximum<br><br>For brain injury, health and disability, and physical disability waivers 7/1/22: \$7,154.65 per year |
| 10. Mental health outreach providers                                    | Fee schedule                  | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 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 7/1/24                                                                                                                                                                                                      |
| 12. Nutritional counseling                                              | Fee schedule                  | Effective 7/1/24 for non-county contract: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$9.85 per 15-minute unit                                                                |
| 13. Assistive devices                                                   | Fee schedule. See 79.1(17)    | Effective 7/1/24: \$1,294.93 per unit                                                                                                                                                                                              |

| <u>Provider category</u>                                      | <u>Basis of reimbursement</u>                                                                                                                                                                                                                                                         | <u>Upper limit</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 14. Senior companion                                          | Fee schedule                                                                                                                                                                                                                                                                          | Effective 7/1/24 for non-county contract: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$2.12 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 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/22 rate: \$6.02 per 15-minute unit, not to exceed \$139.18 per day                                                                                                                                                                                                                                                                                                                   |
| Assisted living program (for elderly waiver only)             | Fee agreed upon by member and provider                                                                                                                                                                                                                                                | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/22 rate: \$6.02 per 15-minute unit, not to exceed \$139.18 per day                                                                                                                                                                                                                                                                                                                   |
| 16. Counseling:                                               |                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Individual                                                    | Fee schedule                                                                                                                                                                                                                                                                          | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.15%, converted to a 15-minute rate. If no 6/30/24 rate: \$12.87 per 15-minute unit                                                                                                                                                                                                                                                                                                                                                 |
| Group                                                         | Fee schedule                                                                                                                                                                                                                                                                          | First 30 minutes: effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$25.74 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group<br><br>Each additional 15 minutes: effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1% converted to a 15-minute rate. If no 6/30/24 rate: \$12.86 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group |
| 17. Case management                                           | Fee schedule                                                                                                                                                                                                                                                                          | For brain injury and elderly waivers: Fee schedule in effect 7/1/24, provider's rate in effect 6/30/24 plus 4.1%                                                                                                                                                                                                                                                                                                                                                                              |
| 18. Supported community living                                | For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)<br><br>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 brain injury waiver effective 7/1/22: \$11.59 per 15-minute unit; \$565.02 daily<br><br>For intellectual disability waiver effective 7/1/24: \$11.59 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 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month                                                                                                                                                                                                                                                                                                                                                                    |
| Long-term job coaching                                        | Fee schedule                                                                                                                                                                                                                                                                          | Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month                                                                                                                                                                                                                                                                                                                                                                    |
| Small-group supported employment (2 to 8 individuals)         | Fee schedule                                                                                                                                                                                                                                                                          | Fee schedule in effect 7/1/24. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month                                                                                                                                                                                                                                                                                                                                        |

| <u>Provider category</u>                                 | <u>Basis of reimbursement</u>                                              | <u>Upper limit</u>                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20. Specialized medical equipment                        | Fee schedule. See 79.1(17)                                                 | Effective 7/1/24, \$7,154.64 per year                                                                                                                                                                                                                                                                               |
| 21. Behavioral programming                               | Fee schedule                                                               | Effective 7/1/24, \$12.87 per 15 minutes                                                                                                                                                                                                                                                                            |
| 22. Family counseling and training                       | Fee schedule                                                               | Effective 7/1/24, \$12.86 per 15-minute unit                                                                                                                                                                                                                                                                        |
| 23. Prevocational services, including career exploration | Fee schedule                                                               | Fee schedule in effect 7/1/24                                                                                                                                                                                                                                                                                       |
| 24. Interim medical monitoring and treatment:            |                                                                            |                                                                                                                                                                                                                                                                                                                     |
| Home health agency (provided by home health aide)        | Fee schedule                                                               | Effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate                                                                                                                   |
| Home health agency (provided by nurse)                   | Fee schedule                                                               | Effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/24 plus 4.1%, 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 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$10.43 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 11.727%                                                                                                            |
| 25. Residential-based supported community living         | Fee schedule for the member's acuity tier, determined pursuant to 79.1(30) | Effective 7/1/24: 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 8/1/25: Provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: \$3.97 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 7/1/24, \$7,154.64 per year                                                                                                                                                                                                                                                                               |
| 28. Family and community support services                | Retrospectively limited prospective rates. See 79.1(15)                    | Effective 7/1/24, \$10.43 per 15-minute unit                                                                                                                                                                                                                                                                        |
| 29. In-home family therapy                               | Fee schedule                                                               | Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: \$27.92 per 15-minute unit                                                                                                                                                                        |
| 30. Financial management services                        | Fee schedule                                                               | Effective 7/1/24, \$77.51 per enrolled member per month                                                                                                                                                                                                                                                             |
| 31. Independent support broker                           | Rate negotiated by member                                                  | Effective 7/1/24, \$18.06 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) "g" (2)                                                                                       |

| <u>Provider category</u>                                                                                                                                                        | <u>Basis of reimbursement</u>                                                                        | <u>Upper limit</u>                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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                                                               | \$29.31 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 7/1/24                                                                                                                                                                                                             |
| 3. Day habilitation                                                                                                                                                             | Fee schedule                                                                                         | Effective 7/1/24: \$3.75 per 15-minute unit or \$72.90 per day                                                                                                                                                                            |
| 4. Prevocational habilitation<br>Career exploration                                                                                                                             | Fee schedule                                                                                         | Fee schedule in effect 7/1/24                                                                                                                                                                                                             |
| 5. Supported employment:                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                           |
| Individual supported employment                                                                                                                                                 | Fee schedule                                                                                         | Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month                                                                                                                |
| Long-term job coaching                                                                                                                                                          | Fee schedule                                                                                         | Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month                                                                                                                |
| Small-group supported employment (2 to 8 individuals)                                                                                                                           | Fee schedule                                                                                         | Fee schedule in effect 7/1/24. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,692.34 per month                                                                                    |
| Individual placement and support supported employment                                                                                                                           | Fee schedule                                                                                         | Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed \$3,692.34 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                                                                                           |



| <u>Provider category</u>                                                 | <u>Basis of reimbursement</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <u>Upper limit</u>                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hospitals (Inpatient)                                                    | Prospective reimbursement.<br>See 79.1(5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Reimbursement rate in effect 10/1/2021                                                                                                                                                                                                                                                                                                       |
| Hospitals (Outpatient)                                                   | Prospective reimbursement or hospital outpatient fee schedule.<br>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%.<br>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"<br>2. Fee schedule for service provided for all other Medicaid members.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare)<br>2. Fee schedule                                                                                                                                                                                                                  |
| Infant and toddler program providers                                     | Fee schedule                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Fee schedule                                                                                                                                                                                                                                                                                                                                 |
| Intermediate care facilities for persons with an intellectual disability | Prospective reimbursement.<br>See 441—82.4(249A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Eightieth percentile of facility costs as calculated from annual cost reports                                                                                                                                                                                                                                                                |
| Lead inspection agency                                                   | Fee schedule                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Fee schedule in effect 6/30/13 plus 1%                                                                                                                                                                                                                                                                                                       |
| Local education agency services providers                                | Fee schedule                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Fee schedule                                                                                                                                                                                                                                                                                                                                 |
| Maternal health centers                                                  | Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Fee schedule in effect 6/30/13 plus 1%                                                                                                                                                                                                                                                                                                       |
| Nursing facilities:<br>1. Nursing facility care                          | Prospective reimbursement.<br>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.<br>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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16) "f." The direct care rate component limit under 441—subparagraph 81.5(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                         |

| <u>Provider category</u>                       | <u>Basis of reimbursement</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>Upper limit</u>                                                                                               |
|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
|                                                | 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 |                                                                                                                  |
| Occupational therapists                        | Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11) “q”                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Fee schedule in effect 6/30/13 plus 1%                                                                           |
| Opticians                                      | Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Fee schedule in effect 6/30/13 plus 1%                                                                           |
| Optometrists                                   | Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Fee schedule in effect 6/30/13 plus 1%                                                                           |
| Orthopedic shoe dealers                        | Fee schedule                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Fee schedule in effect 6/30/13 plus 1%                                                                           |
| 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.<br>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.<br>See 441—Chapter 73                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection |

| <u>Provider category</u>           | <u>Basis of reimbursement</u> | <u>Upper limit</u>                                                                                                                                                |
|------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                    |                               | 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)"k."

*"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 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 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) "j," 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) "j" 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) "j," 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  $2\frac{1}{2}$  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)  $2\frac{1}{2}$  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  $2\frac{1}{2}$  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

| <u>Code</u> | <u>Explanation</u>                                                                                                                                                               |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 numbered paragraph 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 numbered paragraph 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—77.47(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.47(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(15) “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 orxlsx. 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 as amended to July 1, 2026, 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 (rebasings).

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) “k.”

*“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: <ul style="list-style-type: none"> <li>● Ambulance services.</li> <li>● Separately payable clinical diagnostic laboratory services.</li> <li>● Diagnostic mammography.</li> <li>● Screening mammography.</li> <li>● Separately payable nonimplantable prosthetic and orthotic devices.</li> <li>● Physical, occupational, and speech therapy.</li> </ul> | 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.”<br><br>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. <ul style="list-style-type: none"> <li>● May be paid when submitted on a different bill type other than outpatient hospital (13x).</li> <li>● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.</li> </ul>                                                                                                                                                                                                             |
| 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.”<br><br>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: <ul style="list-style-type: none"> <li>● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or</li> <li>● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid.</li> </ul>                                                                                                                                                         | 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.”<br><br>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: <ul style="list-style-type: none"> <li>● 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</li> <li>● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.</li> </ul>                                                                                                                                                               | 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.”<br><br>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<br><br>Corneal tissue acquisition<br><br>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.”<br><br>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.                                                                                                                                                                        |



| Indicator | Item, Code, or Service                                                     | OPPS Payment Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| G         | Pass-through drugs and biologicals                                         | <p>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."</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>                                                                                                                                                                                                                                                                          |
| H         | Pass-through device categories                                             | <p>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."</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>                                                                                                                                                                                                                                                                      |
| J1        | Hospital Part B services paid through a comprehensive APC                  | <p>If covered by Iowa Medicaid, the service is paid under OPPS APC. All covered Part B services on the claim, except services with OPPS SI=F, G, H, L, and U; ambulance services; diagnostic and screening mammography; and all preventive services. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>                                                                                                                                                                                                                         |
| J2        | Hospital Part B services that may be paid through a comprehensive APC      | <p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> <li>● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.</li> <li>● 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.</li> <li>● In other circumstances, payment is made through a separate APC payment.</li> </ul> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p> |
| K         | Non-pass-through drugs and biologicals<br>Therapeutic radiopharmaceuticals | <p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> <li>● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.</li> <li>● 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.</li> </ul> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>                                                                                      |
| L         | Influenza vaccine<br>Pneumococcal pneumonia vaccine                        | <p>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."</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>                                                                                                                                                                                                                                                                    |
| M         | Items and services not billable to the Medicare fiscal intermediary        | <p>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."</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>                                                                                                                                                                                                                                                    |

| Indicator | Item, Code, or Service                                                                 | OPPS Payment Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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. <ul style="list-style-type: none"> <li>● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” or “V.”</li> <li>● In all other circumstances, payment is made through a separate APC payment.</li> </ul>                                                                                                                                                                                                                                                                  |
| Q2        | T-packaged codes                                                                       | Paid under OPPS APC. <ul style="list-style-type: none"> <li>● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.”</li> <li>● In all other circumstances, payment is made through a separate APC payment.</li> </ul>                                                                                                                                                                                                                                                                               |
| Q3        | Codes that may be paid through a composite APC                                         | Paid under OPPS APC. <ul style="list-style-type: none"> <li>● Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.</li> <li>● In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.</li> </ul>                                                                                                                                                                                     |
| 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.” <ul style="list-style-type: none"> <li>● 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.”</li> <li>● 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.”</li> </ul> |
| R         | Blood and blood products                                                               | If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.<br><br>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.<br><br>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.<br><br>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.<br><br>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.”                                                                                                                                                                                                                                                                                                                                                          |

| Indicator | Item, Code, or Service                   | OPPS Payment Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|           |                                          | 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 | <p>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.”</p> <p>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).</p> |

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.

| <u>Service</u>                  | <u>Payment amount</u> | <u>Number of payments</u>      |
|---------------------------------|-----------------------|--------------------------------|
| 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:

"*Coinurance*" 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—79.2(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 daily supported community living services, residential-based supported community living services, full-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 interRAI-Intellectual Disability (interRAI-ID) for individuals age 18 and over and the Child and Youth Mental Health Developmental Disability (ChYMH-DD) (for children and youth below age 18) assessment tools as amended to July 1, 2026. The completed interRAI 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 InterRAI-ID and ChYMH-DD 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. Acuity tier scores are derived from information contained in the following sections:

- (1) Section A. Identification Information
- (2) Section B. Intake and Initial History
- (3) Section C. Community and Social Involvement
- (4) Section D. Strengths, Relationships, and Supports
- (5) Section E. Lifestyle
- (6) Section F. Environmental Assessment
- (7) Section G. Communication and Vision
- (8) Section H. Cognition or Section I. Health Conditions
- (9) Section N. Supports and Services

e. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:

(1) There is a change in the member’s interRAI-ID or ChYMH-DD score 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, a full interRAI-ID or ChYMH-DD assessment shall be conducted and any change in the interRAI-ID or ChYMH-DD scores will be used to determine the member’s acuity tier.

#### **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 2506. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 2506, 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 77.35(5)“c” or “d,” 441—paragraph 77.42(12)“e,” or 441—numbered paragraph 78.9(10)“a”(1)“2,” first bullet point.
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 associate, 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 2506.

*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 2506. 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. Work plans. 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 4A.13. 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 79.9(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 2506.

**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 79.10(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 79.10(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 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 2506.

**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 2506.

**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 79.15(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 79.15(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 2506, 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 2506.

**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 2506.

**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 79.15(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 2506. 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 2506.

**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 79.15(3) or any failure to report a change required by subrule 79.15(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 79.16(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 79.16(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 79.16(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.

[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0317D**

## **HUMAN SERVICES DEPARTMENT[441]**

### **Adopted and Filed**

#### **Rulemaking related to procedure and method of payment**

The Department of Health and Human Services hereby rescinds Chapter 80, “Procedure and Method of Payment,” Iowa Administrative Code, and adopts a new Chapter 80 with the same title.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 249A.

#### *Purpose and Summary*

This chapter 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 sunseting.
- 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 chapter provides guidance on claim format and submission for providers of medical and remedial care that participate in Iowa's medical assistance program.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9851C**. Public hearings were held on the following date:

- January 13, 2026

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 April 16, 2026.

*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 2504.

*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 July 1, 2026.

The following rulemaking action is adopted:

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.

[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0318D**

## **HUMAN SERVICES DEPARTMENT[441]**

### **Adopted and Filed**

#### **Rulemaking related to Medicaid waiver services**

The Department of Health and Human Services hereby rescinds Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code, and adopts a new Chapter 83 with the same title.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 249A.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 249A; 2005 Iowa Acts, chapter 167, section 13; and 2005 Iowa Acts, chapter 117, section 3.

#### *Purpose and Summary*

The purpose of this 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 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 rulemaking are separate and distinct from changes the Department may make to its rules as a result of the upcoming waiver redesign process.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9856C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings.

The Department received a public comment from the National Board for Certification in Occupational Therapy that the Board, not the listed American Occupational Therapy Association, is the organization responsible for certifying occupational therapy practitioners in the United States. As such, the Department has corrected the reference in rule 441—83.60(249A).

The Department updated references to the Supports Intensity Scale® (SIS) assessment for use in the Intellectual Disability Waiver level of care assessments. Use of the SIS assessment ended on December 31, 2025. The tool used now for those level of care assessments is called the interRAI assessment tool.

The Department updated the term “physician assistant” to “physician associate” throughout pursuant to 2026 Iowa Acts, Senate File 2190.

The Department updated the waiver service caps to be current with the amounts as of the effective date of the rules.

The Department also updated references to 441—Chapter 7 to 441—Chapter 2506 to reflect modifications necessitated by the new Uniform Rules on Agency Procedure, which go into effect July 1, 2026.

The Department removed the definition of “case management services” from rule 441—83.81(249A) since the Iowa Code chapter referenced has been repealed.

#### *Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

#### *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 2504.

#### *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 July 1, 2026.

The following rulemaking action is adopted:

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 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Managed care”* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

*“Managed care organization”* or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Medical assessment”* means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility or an intermediate care facility for persons with an intellectual disability that has been approved as a Medicaid vendor.

*“Medical intervention”* means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

*“Member”* means an individual who has been determined to be eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*"Service plan"* means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, the member's family, service providers, and others directly involved with the member.

*"Skilled nursing facility level of care"* means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(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 associate.

*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:

| <u>Skilled level of care</u> | <u>Nursing level of care</u> | <u>ICF/ID</u> |
|------------------------------|------------------------------|---------------|
| \$3,166.53                   | \$1,087.96                   | \$4,244.04    |

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 will 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 2506.

**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—79.10(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 78.34(13), 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 2506.

**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—79.10(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 \$2,128.08.

**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 2506.

**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 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent supported community living service”* means supported community living service provided not more than 52 hours per month.

*“Maintenance needs”* means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

*“Managed care”* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

*“Managed care organization”* or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Medical assessment”* means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

*“Medical intervention”* means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

*“Member”* means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

*“Organization”* means the entity being certified.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified intellectual disability professional”* or *“QIDP”* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the National Board for Certification in Occupational Therapy 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.

*"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 associate.

*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 interRAI assessment tool.
- 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 interRAI assessment tool 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 interRAI assessment tool 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 interRAI assessment or the off-year assessment tool.
  - (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 an interRAI assessment is not completed, the core standardized assessment contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous interRAI or other full assessment. An information assessment tool will be completed annually for children under the age of six. 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 assignment to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the interRAI-ID and ChYMH-DD scores.

**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 2506.

**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”* or *“BI”* 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.

*“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 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent supported community living service”* means supported community living service provided from one to three hours a day for not more than four days a week.

*“Managed care”* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.



*“Managed care organization”* or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Medical assessment”* means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

*“Medical intervention”* means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member’s care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member’s plan of care.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Organization”* means the entity being certified.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified brain injury professional”* means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician associate; 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—79.10(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 associate.
- 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 2506.

**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 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Managed care”* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

*“Managed care organization”* or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Medical institution”* means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*"Physical disability"* means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

*"Service plan"* means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

*"Skilled nursing facility level of care"* means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(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 79.10(1) and 79.10(2).

(2) Adverse decisions may be appealed to the department pursuant to 441—Chapter 2506.

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 \$793.20 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 2506.

**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 the interRAI Early Years 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 Early Years, interRAI - ChYMH and 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, cannot exceed \$2,274.96 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 as amended to July 1, 2026.

(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 2506.

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

[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0319D**

## **HUMAN SERVICES DEPARTMENT[441]**

### **Adopted and Filed**

#### **Rulemaking related to fee-for-service case management**

The Department of Health and Human Services hereby rescinds Chapter 90, "Case Management Services," and adopts a new Chapter 90, "Fee-for-Service Case Management," 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, Iowa Code chapter 249A.

#### *Purpose and Summary*

This rulemaking was undertaken pursuant to Executive Order 10. This 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 (for example, an office visit, test, or procedure). This includes members who qualify for or receive services from the following FFS programs:

- Health Insurance Premium Payment Program (HIPP);
- Medicare Savings Program (MSP);
- Qualified Medicare Beneficiary (QMB);
- Specified Low-Income Medicare Beneficiary (SLMB);
- Emergency Medical Services;
- Medically Needy (also known as the spenddown program); 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 chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of the 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.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 24, 2025, as **ARC 9854C**. Public hearings were held on the following date:

- January 13, 2026

No one attended the public hearings. No public comments were received.

Changes from the Notice have been made. The Department restored language regarding targeted case management application approval and denial in subrule 90.2(3) from the existing rules as opposed to referring to the targeted case management provider manual. The Department also restored language

regarding termination of targeted case management services in subrule 90.3(1) from the existing rules as opposed to referring to the targeted case management provider manual.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on April 16, 2026.

*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 2504.

*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 July 1, 2026.

The following rulemaking action is adopted:

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.

a. Application decision for targeted case management. The TCM provider shall inform the applicant, or the applicant's guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements in 441—Chapter 16.

b. Denial of applications. The TCM provider will deny an application for service when:

- (1) The applicant is not currently eligible for Medicaid;
- (2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);
- (3) The applicant, or the applicant's guardian or representative, withdraws the application;
- (4) The applicant does not provide information required to process the application;
- (5) The applicant is receiving duplicative TCM from another Medicaid provider; or
- (6) The applicant does not have a need for TCM.

**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 TCM services.**

**90.3(1)** TCM shall be terminated only when:

- a. The member does not meet eligibility criteria under rule 441—90.2(249A);
- b. The member has achieved all goals and objectives of the service;
- c. The member has no ongoing need for TCM;
- d. The member is receiving TCM based on eligibility under an HCBS program but is no longer eligible for the program;
- e. The member or the member's guardian or representative requests termination;
- f. The member is unwilling or unable to accept further services; or
- g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of TCM.

**90.3(2)** The provider shall notify the member or the member's guardian or representative in writing of the termination of TCM, in accordance with 441—Chapter 16.

**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 found 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 TCM 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.



[Filed 5/4/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0320D**

## **HUMAN SERVICES DEPARTMENT[441]**

### **Adopted and Filed**

#### **Rulemaking related to certificate of need program and standards for certificate of need review**

The Department of Health and Human Services hereby adopts new Chapter 123, "Certificate of Need Program," and new Chapter 124, "Standards for Certificate of Need Review," Iowa Administrative Code.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code sections 135.61, 135.66, 135.69, 135.71 and 135.72; and 2025 Iowa Acts, House File 972, division VIII.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code sections 135.61 through 135.78; 2025 Iowa Acts, House File 972, division VIII; and 2025 Iowa Acts, House File 1049.

#### *Purpose and Summary*

This rulemaking implements, in part, 2025 Iowa Acts, House File 972, division VIII, which eliminated the Health Facilities Council and transferred the responsibility for approving Certificate of Need applications to the Department. It also transferred the existing Iowa Code sections governing the Certificate of Need process from Iowa Code chapter 10A to Iowa Code chapter 135 within Title IV, Public Health.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on December 10, 2025, as **ARC 9796C**. An Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on April 1, 2026, as **ARC 0175D**. A public hearing was held on the following date(s):

- April 21, 2026

No one attended the public hearing. No public comments were received. No changes from the Amended Notice have been made.

#### *Adoption of Rulemaking*

This rulemaking was adopted by the Department on May 6, 2026.

#### *Fiscal Impact*

This rulemaking has no fiscal impact beyond that outline in the Notes on Bills and Amendments (NOBA) for the underlying legislation, 2025 Iowa Acts, House File 972. That is, the Department of Inspections, Appeals, and Licensing (DIAL) received \$131,757 in FY 2025 from the General Fund Professional Licensing appropriation made to DIAL in 2024 Iowa Acts, Senate File 2433 (FY 2025 Administration and Regulation Appropriations Act) for the duties of the Health Facilities Council. 2025 Iowa Acts, House File 972, eliminated the Council. DIAL also received \$75,984 in application fees

for certificate of need applications in FY 2024. Application fee funds are anticipated to move to the Department as it takes over administration of the Certificate of Need program.

#### *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 2504.

#### *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 July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Adopt the following **new** 441—Chapter 123:

#### *CERTIFICATE OF NEED PROGRAM*

#### CHAPTER 123

#### CERTIFICATE OF NEED PROGRAM

**441—123.1(135) Definitions.** For purposes of this chapter, the following definitions apply:

*“Long-term (acute) care hospital”* means a hospital that has been approved to participate in the Title XVIII (Medicare) program as a long-term care hospital-prospective payment system (LTCH-PPS) hospital in accordance with 42 CFR Part 412 as amended to August 1, 2025.

*“Radiation therapy service applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment,”* as the term applies to new or changed institutional health service in Iowa Code section 135.61(17) “m”(4), means the initiation or expansion of this service.

**441—123.2(135) Letter of intent.**

**123.2(1)** Before applying for a certificate of need, the sponsor of a proposed new institutional health service or changed institutional health service will electronically submit a letter of intent meeting the criteria noted in Iowa Code section 135.64(1).

**123.2(2)** The department will make available on the certificate of need website all criteria and standards pertinent to an application.

**123.2(3)** A letter of intent received by the department is valid for a period of one year from the date of receipt by the department. The sponsor may renew the validity of a letter of intent by providing written notification to the department prior to the one-year expiration date.

**441—123.3(135) Determination of reviewability.** A sponsor of a proposed project may submit a written request for a determination of reviewability as to whether the project requires a certificate of need.

**123.3(1)** If it is determined that a certificate of need is required, the department will notify the sponsor and the request for nonreviewability will be considered the letter of intent for purposes of subrule 123.2(2).

**123.3(2)** If it is determined that a certificate of need is not required, the department will notify the sponsor of the determination of nonreviewability.

**441—123.4(135) Submission of application.**

**123.4(1)** Application form.

*a.* A sponsor of a proposed project for a new or changed institutional health service will submit to the department an application for certificate of need using the appropriate application form found on the certificate of need website. All information requested in the application form is required in the absence of a waiver by the department.

*b.* An original application and all attachments shall be submitted electronically.

*c.* The department will establish and maintain electronic files on each application.

**123.4(2)** The application fee specified in Iowa Code section 135.62(1) is based on the total cost of the project, including site costs, land improvements, facility costs, movable equipment, and financing costs.

*a.* The fee for leased or donated new institutional health services is calculated in the same manner as if the new institutional health services were purchased.

(1) The leased equipment fee is based on total value of the lease, plus sales tax, delivery and installation.

(2) The lease of space includes the cost of a one-year lease payment for the space, in addition to other costs associated with the project.

(3) Financing costs are not applicable on leases or cash purchases.

*b.* The application fee will be refunded by the department for any application that is voluntarily withdrawn from the review process in the amounts specified in Iowa Code section 135.62(1).

*c.* For purposes of this subrule and Iowa Code section 135.62(1), “submission” means the day the application is received by the department.

**123.4(3)** The notice of an accepted application issued pursuant to Iowa Code section 135.65(2) will inform the applicant and affected persons of the deadlines for the electronic submission to the department of written statements or other materials.

**441—123.5(135) Organizational procedures.**

**123.5(1)** The department will evaluate the application against the criteria specified in Iowa Code section 135.63.

**123.5(2)** Public comments on an application.

*a.* The department will receive written public comments on an application during a time frame prescribed by the department for each application. Oral comments will be received at a public hearing set by the department.

*b.* Public hearings conducted pursuant to Iowa Code section 135.65(3) “*b*” are not contested cases.

**441—123.6(135) Summary review.** Summary review may be utilized at the discretion of the department pursuant to Iowa Code section 135.66. An applicant requesting a summary review will abide by the following procedures:

**123.6(1)** An applicant will electronically submit a written request for summary review and a copy of the application and all attachments. An applicant is not required to submit a letter of intent pursuant to Iowa Code section 135.64 prior to submitting a written request for a summary review.

**123.6(2)** The eligibility of an application for summary review pursuant to Iowa Code section 135.66 does not mandate or require such review. The department will make the decision as to whether an application will be reviewed in the summary review process.

**123.6(3)** Upon receipt of a written request for summary review, an application, and the fee required by Iowa Code section 135.62(1), the department will notify the applicant in writing within 15 calendar days if the application is complete and if a summary review will be granted.

**123.6(4)** If an application is deemed incomplete, the department will state specifically in writing what information is needed to make the application complete.

**123.6(5)** If the department notifies an applicant that a summary review will not be performed, this decision is binding on the applicant and the application will be entered into the formal review process on the date of written notice that such application will not be reviewed summarily.

**123.6(6)** A summary review of an application for a certificate of need will be completed within 60 calendar days of the acceptance of an application by the department. Summary review will follow the process outlined on the department's website.

**123.6(7)** At any time during the summary review process, an application may be withdrawn without prejudice from the process. An applicant may then submit the application for a formal 90-day review.

**441—123.7(135) Extension of review time.**

**123.7(1)** A formal review of an application for a certificate of need pursuant to Iowa Code section 135.65 may be extended by the department on the basis of any of the following criteria:

- a. In order to review competing applications simultaneously;
- b. In the case of technologically innovative equipment, to obtain additional information necessary to evaluate the proposal. The department will specify in writing such additional information as necessary;
- c. At the request of an applicant;
- d. At the request of the department in order to allow additional time for deliberation on all evidence present. The department will specify the time of the delay and the date on which the final decision will be rendered.

**123.7(2)** An extension by the department made pursuant to subrule 123.7(1) will in no case be more than 60 calendar days beyond the time a decision is required under Iowa Code section 135.68 unless the applicant and the department agree.

**123.7(3)** Where none of the provisions of subrule 123.7(1) are applicable and where an application will be automatically denied because of the expiration of time required by Iowa Code section 135.68 for the issuance of a written decision by the department, the department will notify the applicant of the likelihood of an automatic denial and will ask the applicant to request in writing an extension of the review time.

**441—123.8(135) Rehearing of certificate of need decision.**

**123.8(1)** An applicant or any affected person who has participated or sought unsuccessfully to participate in the formal review procedure prescribed in Iowa Code section 135.65 may, for good cause shown, file an application for rehearing in writing with the department stating the specific grounds therefor and the relief sought within 20 calendar days after the date of the issuance of the final decision on an application for certificate of need.

**123.8(2)** Grounds for rehearing include but are not limited to:

- a. New significant, relevant information that was unavailable at the date of the hearing;
- b. Significant changes in factors or circumstances relied upon by the department in reaching its decision;
- c. Demonstration that the department has materially failed to follow its adopted procedures in reaching its decision; or
- d. Such other bases as the department determines constitute good cause.

**123.8(3)** An application for rehearing is deemed to have been denied unless the department grants the application in writing within 20 calendar days after its filing.

**123.8(4)** If the application for rehearing is granted, the department may issue an order modifying the initial final order. At the department's discretion, public hearing may be granted on the application for rehearing and notice will be provided ten calendar days prior to the rehearing to the person applying for rehearing, the applicant and other affected persons upon request.

**123.8(5)** The department will issue the final decision on rehearing, stating the basis for its decision, within 60 calendar days after the application for rehearing was granted or 60 calendar days after public hearing or rehearing, whichever is later.

**123.8(6)** If a rehearing is not requested or an affected party remains dissatisfied after the request for rehearing, an appeal may be taken in the manner provided by Iowa Code chapter 17A. A request for rehearing is not required prior to appeal under Iowa Code section 17A.19.

**441—123.9(135) Finality.** The certificate of need application process is continuous beginning with submission of a letter of intent or request for waiver of a letter of intent through issuance of a final decision by the department subject to judicial review under Iowa Code chapter 17A.

**123.9(1)** The following stages of the process are intermediate and subject to judicial review only to the extent the stages meet criteria for intermediate review under Iowa Code section 17A.19:

- a.* A decision by the department pursuant to rule 441—123.3(135) that a proposed project does not require a certificate of need;
- b.* A decision by the department to waive submission of the letter of intent and substitute summary review; and
- c.* The rejection of an application by the department that fails to provide all information required under Iowa Code section 135.62(1).

**123.9(2)** The following stages of the process are final decisions subject to judicial review as final agency action under Iowa Code section 17A.19:

- a.* A decision by the department to disallow summary review;
- b.* A decision by the department that a proposed project does not require a certificate of need;
- c.* A decision by the department to approve or deny an application;
- d.* The department's final decision on an application for rehearing; and
- e.* A decision by the department to revoke a certificate of need pursuant to rule 441—123.10(135).

**441—123.10(135) Request for extension of certificate.**

**123.10(1)** A request by an applicant for an extension of a certificate of need will be filed with the department using the form available on the certificate of need website no later than 30 days prior to the expiration of the certificate of need.

**123.10(2)** When an extension has been requested, the department will approve or deny the request prior to expiration of the certification. The certificate of need may be revoked by the department at the end of the certification period for insufficient progress in developing the project.

**123.10(3)** If an extension is denied, an applicant has the right to appeal under the provisions of Iowa Code section 135.69.

**441—123.11(135) Application changes after approval.**

**123.11(1)** Once a project has been approved by the department, no changes that vary from or alter the number of approved beds, the approved services or the approved cost by an amount indicated in subrule 123.11(2) may be made unless requested by the applicant and approved by the department. Requests should be made in writing and filed with the department electronically.

**123.11(2)** An increase in the actual cost of the project over and above that originally approved will automatically generate review by the department if the increase exceeds the originally approved amount by:

- a.* Fifteen percent for projects up to \$999,999.99;
- b.* Twelve percent for projects from \$1 million to \$4,999,999.99;
- c.* Eight percent for projects \$5 million and over.

An increase in the approved cost that falls below the above percentages will be reported to the department.

**123.11(3)** Failure to notify and receive permission of the department to change the project as originally approved may result in the imposition of sanctions as provided in Iowa Code section 135.72. The department may make a recommendation regarding the imposition of a sanction and the amount of the fine to be imposed.

**441—123.12(135) Sanctions.** Hearings to determine class I or class II violations pursuant to Iowa Code section 135.72 will be conducted in accordance with 441—Chapter 7.

These rules are intended to implement Iowa Code sections 135.61 through 135.78.

ITEM 2. Adopt the following **new** 441—Chapter 124:

CHAPTER 124  
STANDARDS FOR CERTIFICATE OF NEED REVIEW

**441—124.1(135) Cardiac catheterization and cardiovascular surgery standards.**

**124.1(1) Purpose and scope.**

a. These standards are measures of some of those criteria found in Iowa Code section 135.63(1)“a” through “q” and 135.63(3). Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these cardiac catheterization and cardiovascular surgery standards include:

- (1) Proposals to commence or expand capacity to perform cardiac catheterization.
- (2) Proposals to add new or replace cardiovascular surgery services.
- (3) Any other applications that relate to cardiac catheterization or cardiovascular surgery.

**124.1(2) Definitions.** The following definitions apply to the terms used in this rule:

“*Adult cardiac catheterization laboratory*” means a diagnostic facility exclusively for intracardiac or coronary artery catheterization on adults.

“*Adult cardiovascular surgery*” means cardiovascular surgery exclusively for adults.

“*Angiocardiography*” means the recording of moving X-ray images (fluoroscopic images) of the heart and great vessels. After injection of radiopaque chemicals, moving X-rays of the chemical’s flow are projected on a screen called a fluoroscope. Moving pictures (cineangiography) or still pictures in sequence (serialography) may be recorded of the X-ray image.

“*Angiography*” means the photographic recording of X-ray or radiologic images of blood vessels in any part of the body—the heart, the head, the great vessels, the kidney, etc. In the procedure, blood vessels are injected with a radiopaque chemical. Immediately following injection, X-rays are employed to image the path of the injected chemical. These X-ray images are then photographically recorded.

“*Cardiovascular surgery*” means the services associated with and surgery performed for congenital or acquired diseases of the heart, great vessels, or pericardium, including the placement of transvenous and epicardial pacemakers.

“*Closed heart surgery*” means cardiovascular surgery in which a small incision and repairs are made without direct vision of the area.

“*Coronary artery catheterization*” means a diagnostic study of the coronary arteries in which a small catheter passes through an artery in the leg, neck or arm into a coronary artery orifice. Intravascular pressure measurements are taken, and angiography of the coronary arteries is performed. Catheterization and cineangiography of the left ventricle are an integral part of this procedure.

“*Coronary artery surgery*” means surgery to correct inadequate blood flow to the heart using revascularization techniques to bypass significantly obstructed coronary artery lesions.

“*Intracardiac*” means a diagnostic study of the heart, pulmonary arteries, or both in which a small catheter passes through a vein or artery in the neck, leg or arm and advances into the great vessels, the heart or the pulmonary arteries. Through this procedure, one can measure pressure within the heart and in adjacent veins and arteries, collect blood samples for blood gas analysis and inject radiopaque material, and visualize cardiac and vessel anatomy. The procedure permits detection of congenital and acquired heart abnormalities, the study of ventricular function, the estimation of the orifice size, the placement of pacemakers, etc. Cardiac catheterization is incomplete without cineangiography, intracardiac pressure measurements, blood gas analysis and the ability to diagnose intracardiac shunts.

“*Open heart surgery*” means cardiovascular surgery in which an incision of sufficient size is made to allow direct vision of the area. Open heart surgery requires temporary use of a heart-lung (cardiopulmonary bypass) machine since blood flow through the heart is greatly reduced or stopped altogether.

*“Pediatric cardiac catheterization laboratory”* means the same as adult cardiac catheterization laboratory, except exclusively for children and infants.

*“Pediatric cardiovascular surgery”* means cardiovascular surgery exclusively for infants and children.

**124.1(3) Availability of services.**

*a. Minimum utilization—cardiovascular surgery* (Iowa Code section 135.63(1) “c,” “g,” and “h”).

(1) Adult cardiovascular surgical programs should project an annual minimum rate of over 200, or no approval will be granted. Higher case loads over 200 per annum are encouraged.

(2) Pediatric cardiovascular surgical units should project a minimum of 100 pediatric heart operations after the first year, at least 75 of which must be open heart procedures.

(3) Combined adult and pediatric cardiovascular surgery units should project the minimum projected annual rates for both adult and pediatric surgery.

(4) An applicant should project utilization of cardiovascular surgery, catheterization and cardiac care units based upon service area population demographics, current regional or national utilization rates of the service, disease incidence and prevalence rates, current cardiac care treatment modes, and in consideration of those adult cardiovascular surgery units currently operating in Iowa and bordering states within the project’s service area.

*b. Expansions—cardiovascular surgery* (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”).

(1) There should be no additional adult cardiovascular surgery units initiated unless each existing unit within the project’s service area is operating at a minimum of 200 open heart surgery cases per year.

(2) There should be no additional pediatric cardiovascular surgery units initiated unless each existing unit within the project’s service area is operating at 100 surgeries per year. If one team serves more than one institution, the numbers for those institutions should be combined.

(3) If the annual utilization of the other cardiovascular surgery units within the area is below the levels noted above, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the level must be demonstrated.

(4) An applicant will demonstrate that an attempt was made to determine with the cooperation of existing providers whether such a reduction would occur. Existing providers of consequence are generally within two hours’ surface travel time for adult services and within three hours’ surface travel time for pediatric services.

*c. Minimum utilization—cardiac catheterization* (Iowa Code section 135.63(1) “c,” “d,” “g,” and “h”).

(1) Adult cardiac catheterization laboratories should be projected to operate at a minimum of 300 catheterizations per annum.

(2) Pediatric catheterization laboratory units should project a minimum of 150 catheterizations per annum.

(3) Combined units should meet each of the adult and pediatric standards.

(4) An applicant should project utilization of cardiac catheterization units based upon service area population demographics, current regional or national utilization rates of the service, disease incidence and prevalence rates, current cardiac care treatment modes, and in consideration of those adult cardiovascular surgery units currently operating in Iowa and bordering states within the project’s service area.

*d. Expansions—cardiac catheterizations* (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”).

(1) There should be no additional adult cardiac catheterization unit opened unless the number of studies per year in each existing unit within the project’s service area is greater than 300. No additional pediatric unit should be opened unless the number of studies per year in each existing unit within the project’s services area is greater than 150.

(2) If the annual utilization of the other cardiovascular surgery units within the area is below the levels noted above, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the level must be demonstrated.

(3) An applicant must demonstrate that an attempt was made to determine with the cooperation of existing providers whether such a reduction would occur. Existing providers of consequence are those within two hours' surface travel time for adults or three hours' surface travel time for pediatrics.

**124.1(4) Costs.**

*a. Financial feasibility.* (Iowa Code section 135.63(1) "f," "i," and "p") Cardiovascular surgery and catheterization equipment and associated remodeling or construction should be depreciated over a period consistent with generally accepted accounting standards.

*b. Cost-effectiveness.* Proposed new or replacement cardiac catheterization laboratories cost per catheterization and cardiovascular surgery services estimated costs per surgery should, when compared to their peers, demonstrate cost-effectiveness.

**124.1(5) Accessibility.** (Iowa Code section 135.63(1) "c" and "d")

*a.* Cardiovascular surgery units and cardiac catheterization labs should meet the needs of the communities that the units and labs are meant to serve.

*b.* Cardiac catheterization and cardiovascular surgery service should be provided regardless of ability to pay in consideration of those programs available in the state that serve the medically indigent.

**124.1(6) Quality.** (Iowa Code section 135.63(1) "i" and "k")

*a.* Each surgery unit and cardiac catheterization lab shall demonstrate a reasonable set of criteria that are used in selecting appropriate candidates for surgery and catheterization.

*b.* Staffing minimums.

(1) The open heart surgery team should minimally consist of:

1. At least two certified or board-eligible cardiovascular surgeons for the first 75 to 130 pediatric open heart surgeries. If pediatric surgery is performed, one surgeon must have special training and experience in surgery for congenital cardiac defects.

2. Board-certified or board-eligible adult or pediatric cardiologist(s). The latter only if pediatric surgery is performed, the former only if adult surgery is performed.

3. Board-certified or board-eligible anesthesiologist with special training in the management of cardiovascular cases' respiratory care.

4. Radiologist trained in the cardiovascular field.

5. Pathologist familiar with cardiac problems.

6. Surgical nursing staff specially trained in heart disease.

7. Cardiopulmonary bypass pump technicians.

8. Other ancillary staff as needed.

(2) Each applicant will document that the proposed surgery unit can be so staffed when completed and operational.

*c.* Equipment and facilities. An applicant seeking to provide cardiovascular surgery should demonstrate that the following support services will be available:

(1) General X-ray diagnostic facilities and facilities for emergency X-rays on a 24-hour basis.

(2) A cardiac catheterization laboratory or angiography lab available on a 24-hour basis.

(3) A cardiographics laboratory with facilities for recording the following tests: EKG, vector cardiogram, phonocardiogram, echocardiogram, and exercise stress testing.

(4) A supporting blood bank and hematology laboratory.

(5) A microbiology laboratory.

*d.* Cardiac catheterization labs serving infants and children should have biplane angiographic equipment, either cineangiographic or cut film. Pediatric cardiac catheterization labs should be supervised by board-certified or board-eligible pediatric cardiologists; adult cardiac catheterization labs should be supervised by a board-certified or board-eligible adult cardiologist.

**124.1(7) Continuity.** (Iowa Code section 135.63(1) "g," "h," "i," and "k")

*a.* An applicant should demonstrate that an attempt was made to solicit letters of support from area hospitals and physicians to indicate a community need.

*b.* An applicant should provide documentation that emergency medical transport services will be available.



c. Institutions providing cardiovascular surgery services should include mechanisms for comprehensive medical followup, including adequate medical records exchange.

**124.1(8) Acceptability.** (Iowa Code section 135.63(1)) Facilities with cardiovascular surgery and cardiac catheterization indicate a willingness to observe and respect the rights of patients.

**441—124.2(135) Radiation therapy standards.**

**124.2(1) Purpose and scope.**

a. These standards provide guidelines to assist the department in applying those criteria in Iowa Code section 135.63(1) “a” through “r” and 135.63(3). Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these radiation therapy standards include:

(1) Proposals to commence or expand the kind or capacity of megavoltage radiation therapy services.

(2) Proposals to replace a megavoltage radiation therapy unit.

(3) Any other applications that relate to megavoltage radiation therapy.

**124.2(2) Definitions.** The following definitions apply to the terms used in this rule:

“*Computed tomography*” or “*CT*” means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

“*Conjoint radiation oncology center*” or “*cancer center*” means a multi-institution, multidisciplinary network to provide radiation therapy for cancer patients. Integration of patient care management, common utilization of personnel and equipment, and a single system of records between center institutions ensures optimal care regardless of entry portal.

“*Dosimetrist*” means a staff member who calculates, verifies, and develops treatment plans for the radiation dose distributions that will be delivered to patients. The dosimetrist is an essential member of the treatment planning team and works closely with radiation oncologists and radiation physicists.

“*Megavoltage therapy*” means the use of ionizing radiation in excess of 1 million electron volts. Energies above 1 million electron volts cause considerably less skin damage, increase depth dose markedly, and result in much less scatter from the therapeutic beam. Megavoltage machines are classified as follows:

1. Electron accelerator. A machine such as a linear accelerator that uses a supply of electrons, which are accelerated into high-energy beams. These electron beams are either caused to strike a target resulting in high-energy X-ray production or are used themselves as the treatment beam. Electron accelerators generate over 1 million electron volts.

2. Heavy particle accelerator. A machine such as a cyclotron that produces beams of high-energy particles such as protons, neutrons, pions, carbon ions, or other heavy ions with masses greater than that of an electron.

3. Isotope sources (gamma ray teletherapy units). Cobalt 60 units—emit gamma rays of approximately 1.2 million electron volts.

“*Megavoltage therapy unit*” means a piece of megavoltage therapeutic radiologic equipment that provides megavoltage therapy.

“*New occurrence*” means a course of treatment for a new occurrence on a given patient at a given radiation therapy facility. First-time radiation therapy at a new facility is based on each round of treatment.

“*Radiation modality*” means the method of applying ionizing radiation in the treatment of patients with malignant disease using megavoltage external beam equipment.

“*Radiation oncologist*” means a physician authorized user trained in accordance with rule 641—42.5(136C).

“*Radiation therapy facility*” or “*facility*” means the physical space that houses a megavoltage therapy unit and accompanying support equipment.

*“Radiation therapy physicist”* means an individual who works closely with radiation oncologists and is responsible for the safe and accurate delivery of radiation to patients. A radiation therapy physicist conducts quality control programs for the equipment and procedures and calibrates the equipment. A radiation therapy physicist shall practice in accordance with rule 641—42.6(136C).

*“Radiation therapy technologist”* means an individual who possesses an Iowa permit to practice as a radiation therapist in accordance with rule 641—38.4(136C).

*“Service area”* means the county in which the facility is located and any other counties from which an applicant expects to draw patients with a cancer diagnosis who need radiation therapy treatment.

*“Simulation”* means the precise mock-up of a patient treatment with an apparatus that uses planar X-rays, a magnetic resonance imaging device, or a computed tomography scanner, which is used in reproducing the two-dimensional or three-dimensional internal or external geometry to the patient, for use in treatment planning and delivery.

*“Superficial X-ray therapy”* means the use of a conventional X-ray machine, which generates X-rays of up to 150 kilovolts (kv), to treat superficial lesions, such as skin cancer.

*“Treatment”* means radiation fields applied in a single patient visit fraction or delivery session.

**124.2(3) Availability.**

*a. Minimum utilization.* (Iowa Code section 135.63(1) “c,” “g,” and “h”)

(1) A megavoltage radiation therapy unit and cobalt units should treat at least 250 new occurrences annually within three years after initiation of the service.

(2) The expected number of new occurrences needing megavoltage radiation therapy annually in a service area should be calculated as follows:

1. Multiply the service area population by 0.00582 (5.82/1,000 population was the mean cancer incidence rate in 2017 in Iowa as filed by the Surveillance, Epidemiology, and End Results (SEER) Program).

2. Multiply this product by 0.5 (50 percent of all new occurrences receive radiation therapy).

(3) The expected volume of utilization sufficient to support the need for a new megavoltage therapy unit should be calculated as follows: Each unit shall provide a minimum of 5,000 treatments per annum. Megavoltage treatments should be projected by multiplying the number of projected new occurrences needing megavoltage therapy by 20, which will result in no fewer than 5,000 treatments per annum.

(4) An applicant shall account for other providers of radiation therapy in the service area, including but not limited to factors such as technological capability and quality. An applicant shall address in the applicant’s application other providers and the impact on those providers in the service area and compare technological capability and quality.

(5) An applicant should provide a map of the expected service area.

(6) Institutions that form a conjoint oncology center should have at least 500 new occurrences annually.

*b. Simulator availability.* A simulator should be available within a radiation oncology department.

**124.2(4) Accessibility.** (Iowa Code section 135.63(1) “c” and “d”) Radiation therapy services should be provided regardless of ability to pay in consideration of those programs available in the state that serve the medically indigent.

**124.2(5) Quality.** (Iowa Code section 135.63(1) “i” and “k”)

*a. Minimum staffing requirements for radiation therapy facilities.* Each facility:

(1) Will have the services of at least one radiation oncologist.

(2) Will have the services of at least one radiation therapy physicist.

(3) Will have the services of radiation therapy technologists that should be staffed at a level of two technologists per megavoltage unit.

(4) Should have the services of nurses.

(5) Should have the services of at least one dosimetrist.

(6) Should have the services of one radiation therapist or radiation technologist competent to operate a CT simulator.

(7) Should offer psychosocial counseling services and nutritional counseling.

*b. Minimum staffing requirements for conjoint centers.* Each center:

- (1) Will have at least two cancer biologists available.
- (2) Will have one radiation technologist available for each simulator.
- (3) Should have a source of continuing education to reach participating community referral hospitals and physicians.
- (4) Should have a unified training program in radiation therapy for radiation oncologists.
- c. The long-range plans for radiation therapy services shall be submitted to the department.
- d. Multidisciplinary tumor boards should be established in all institutions housing megavoltage machines.

**124.2(6) Continuity.** (Iowa Code section 135.63(1)“g,” “h,” “i,” and “k”) An applicant should demonstrate that an attempt was made to solicit letters and establish referral agreements from area hospitals and physicians to indicate their willingness to participate in a cooperative endeavor to refer to the proposed service.

**441—124.3(135) Computerized tomography standards.**

**124.3(1) Purpose and scope.**

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1)“a” through “l.” Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these computerized tomography standards include:

- (1) Proposals to commence or expand the capacity of computerized tomography services.
- (2) Any other applications that relate to computerized tomography services.

**124.3(2) Definitions.** The following definitions apply to the terms used in this rule:

“*Active oncology service*” means full, multidisciplinary cancer care, provided by a medical team that would include: surgery, gynecology, medical oncology, radiation oncology, pathology, diagnostic radiology and nuclear medicine. The surgery specialties that might be available would include: thoracic, abdominal, genitourinary and gynecological. The active oncology staff would include those specialists with training in oncology, hematology, and pathology and who spend at least half of their time at the institution.

“*Applicant*” means a facility or a consortium of facilities within an area or a physician or group of physicians.

“*Chemotherapy service*” means the treatment of cancer by chemical agents.

“*Computerized tomographic (CT) scanner*” means a diagnostic tool that rotates around the body and that sends X-ray beams through the body or brain. The X-ray beams that emerge from the body or brain are absorbed by a detector. Differences in the amount of X-rays absorbed by the detector indicate differences in tissue density. As the scanner rotates, it takes many images of a volume or cross-section. The images on the detector are transmitted to a computer that displays on a monitor a reconstructed cross-sectional slice or volume. Contrast media is often injected to alter absorption of the detector. If the scan is repeated, it is called enhancement. Studies of the heart, arteries and veins may be done with contrast only.

“*CT consortia*” means a cooperative venture in which two or more institutions form a separate entity that is created for the purpose of owning, leasing, planning for, and maintaining the use of the scanner. Each facility in the consortium maintains its autonomy for all other services.

“*Emergency medical service (EMS) level II trauma service*” means the level of various services and staffing that qualify a facility to be designated by the department, using the facilities categorization criteria of such services that is in effect on the date of the enactment of this standard.

“*Enhanced scan*” means a scan performed on a patient who has been administered a contrast medium so that specific organs or areas of the body will be displayed more distinctly on the scan image.

“*General imaging procedures*” means a radiological diagnostic procedure performed on an X-ray machine or similar radiological diagnostic instrument.

“*Head scanner*” means a scanner capable of imaging only the brain and structures adjacent to the head.

*“Minimum shared-market area for a scanner”* (hereafter referred to as “area”) means the smallest geographic area within which any scanner installation is judged to affect the utilization rate of any other scanner in the community (as defined by the U.S. Bureau of the Census) or a standard metropolitan statistical area (where an area is so designated).

*“Radiotherapy service”* means the therapeutic application of megavoltage radiation, using a linear accelerator or cobalt unit. The availability of such service at a hospital would necessitate personnel trained in the therapeutic application of radiology.

*“Shared service agreement”* means a multi-institutional arrangement for coordination or consolidation of services or sharing of support services. Among the various types of arrangements are referred services, purchased or joint contract services, multisponsored services and regional services.

*“Whole body scanner”* means a scanner capable of imaging the entire body.

**124.3(3) Determination of need.**

*a.* An applicant who does not have a scanner or an applicant who has a scanner and seeks a certificate for one or more additional scanners.

(1) An applicant in areas with no other scanners.

1. An applicant must have performed at least 30,000 general imaging procedures during the past calendar year or 12 months, or

2. An applicant must demonstrate that during the past calendar year or 12 months, the applicant has performed diagnostic procedures equivalent to 1,500 head equivalent CTs (HECTs), using the following: 100 percent of the number of patients referred to other facilities for CT diagnosis  $\times$  1.75 (in the case of head scans) and 2.75 (in the case of body scans).

(2) An applicant in an area with one or more scanners.

1. An applicant must meet the requirement of need described in subparagraph 124.4(3)“a”(1), and

2. The average level of utilization for scanners within the area was at least 3,000 HECTs (plus or minus 10 percent) for the past calendar year or 12 months. The average level of utilization will be determined by adding the number of HECTs performed during the period at all area facilities divided by the number of facilities.

3. University of Iowa Health Care is specifically exempted from consideration under numbered paragraph 124.3(3)“a”(2)“2” because it has a service area that encompasses the entire state and adjoining states. The utilization statistics for scanners at the University of Nebraska Medical Center and Creighton University Medical Center – Bergan Mercy (both in Omaha) will not affect the need for scanners at hospitals in Council Bluffs.

*b.* Replacement scanners—applicant who currently has a scanner.

(1) An applicant seeking to replace a scanner with another scanner, head or body.

1. An applicant must demonstrate that the applicant’s use of the applicant’s current scanner was at least at the operating capacity level during the last calendar year or 12 months, or

2. An applicant must demonstrate that the applicant’s use of the applicant’s current scanner was at least below the operating capacity level, but above the 1,500 CT scan level, and the applicant must demonstrate reasons for permanently utilizing the applicant’s scanner below operating capacity level and demonstrate that discontinuation of the applicant’s scanner service would impair the applicant’s ability to respond to the emergency needs of the area. Reasons for utilizing the scanner below the capacity should include a unique patient or procedure mix that would define the capacity level differently for the applicant.

(2) Reserved.

**124.3(4) Costs and financial feasibility.** (Iowa Code section 135.63(1)“f,” “i,” and “p”)

*a.* CT scanners should be depreciated over a period of not less than seven years. Remodeling shall be depreciated as appropriate by generally accepted accounting principles.

*b.* Cost-effectiveness. An applicant should demonstrate for the applicant and the health care system that the most cost-effective method of providing CT services has been chosen. A proposed new and replacement CT scanner’s cost per CT scan should, when compared to the applicant’s peers, demonstrate cost-effectiveness.

**124.3(5) Accessibility.** (Iowa Code section 135.63(1)“c” and “d”)

- a. All scanners must be available to meet the needs of the communities the scanners are meant to serve.
- b. Services should be provided to all patients regardless of the patients' ability to pay, taking into consideration the availability of those programs available in the state that serve the medically indigent.
- c. An applicant will demonstrate a willingness to accept referrals for CT services from all area physicians.

**124.3(6) *Quality.*** (Iowa Code section 135.63(1) "i" and "k")

- a. Data on use and costs of the CT scanners should be submitted to the Iowa department of health and human services as a condition of approval. (Iowa Code section 135.63(1) "a" and "h")

- b. All scanners.

(1) An applicant must demonstrate that the applicant has on its staff or will acquire on its staff a full-time diagnostic radiologist trained in the use of the CT scanner or other physicians with comparable training and expertise.

(2) An applicant must document that the applicant has on its medical staff individuals who are qualified to operate a scanner and interpret and act upon the diagnostic results. Such documentation may include reference to board certification, apprenticeship, academic credentials or such other qualifications that would prompt a medical staff to accept the responsibility for offering this new service. An applicant that intends to acquire staff with the desired expertise should provide signed letters of intent from the incoming medical personnel. An applicant that intends to upgrade the specialty skills of its staff should document a plan for training its current staff in the use of CT scanners.

(3) An applicant should have a complement of other diagnostic modalities available. An applicant seeking body scanners should also have available ultrasound and conventional X-ray services.

(4) An applicant should have the facilities for treating the conditions diagnosed by imaging with the scanner or should demonstrate referral agreements with treatment facilities in the event that the scanner will be used as a screening device.

(5) An applicant should have on its staff or available on a consultative basis the services of a biomedical engineer or medical physicist with special training in CT applications. These functions may also be provided by contract with the scanner manufacturer.

**124.3(7) *Continuity.*** (Iowa Code section 135.63(1) "g," "h," "i," and "k")

- a. An applicant should demonstrate that an attempt was made to solicit letters of support from area hospitals and physicians to indicate a community need for the proposed service.

- b. An applicant should provide documentation that emergency medical transport services will be available.

- c. An applicant should demonstrate an emphasis on the availability of outpatient CT procedures and that an appropriate percentage of all CT procedures will be done on an outpatient basis.

**124.3(8) *Acceptability.*** (Iowa Code section 135.63(1) "k") Providers of CT services should indicate a willingness to observe the rights of patients.

**441—124.4(135) Long-term care.**

**124.4(1) *Purpose and scope.***

- a. These standards are measures of criteria found in Iowa Code section 135.63(1) "a" through "g." Criteria that are measured by a standard are cited in parentheses following each standard.

- b. Certificate of need applications that are to be evaluated against these standards include applications to:

- (1) Construct, develop, offer new, modernize, replace, renovate, or relocate intermediate care or skilled nursing care beds in nursing homes or hospitals.

- (2) Expand bed capacity in intermediate care or skilled nursing care facilities or designated units in hospitals.

**124.4(2) *Definitions.*** The following definitions apply to the terms used in this rule:

"Intermediate care facility" or "ICF" means any institution, place, building, or agency providing for a period exceeding 24 consecutive hours accommodation, board, and nursing services, the need for which is certified by a physician, to three or more individuals, not related to the administrator or owner

thereof within the third degree of consanguinity, who by reason of illness, disease, or physical or mental infirmity require nursing services that can be provided only under the direction of a registered nurse or a licensed practical nurse.

*“Skilled nursing facility”* or *“SNF”* means any institution, place, building, or agency providing for a period exceeding 24 consecutive hours accommodation, board, and nursing services, the need for which is certified by a physician, to three or more individuals not related to the administrator or owner thereof within the third degree of consanguinity who by reason of illness, disease, or physical or mental infirmity require continuous nursing care services and related medical services but do not require hospital care. The nursing care services provided must be under the direction of a registered nurse on a 24-hour-per-day basis.

**124.4(3) Availability and need.** (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”)

a. The following formula will be used as a means of projecting the approximate number of beds needed by level of care (intermediate or skilled nursing care) to serve the projected population one year into the future using county-level characteristics:

(1) County-level bed need = County-level bed-days / days in time period

County-level bed-days = exp(Linear Predictor)

Linear Predictor = Intercept

+ Weight for Log of Total Population × Log of Total Population

+ Weight for Percent age 65-74 × Percent age 65-74

+ Weight for Percent age 75-84 × Percent age 75-84

+ Weight for Percent age 85 plus × Percent age 85 plus

+ Weight for Level of care × Level of care

+ Weight for Time Trend × Time Trend

+ Weight for Level of care × Time Trend × Level of care × Time Trend

+ Month effect for applicable month

+ County effect for applicable county

(2) For the purposes of using this formula, the lower and upper bounds of the weights for each variable in this section can be found on the department’s website at [hhs.iowa.gov/certificate-need-con-program](https://hhs.iowa.gov/certificate-need-con-program).

(3) Bed need formula projections will consider county of facility, seasonal variation in need, age range of population, future population change projections, and other relevant factors and controls.

(4) The department will review the bed need formula at least every three years.

b. For purposes of comparing “need” to “existing” beds in a given county, the following shall be considered in the calculation of “existing” beds:

(1) ICF and SNF beds licensed at freestanding facilities in the county.

(2) Additional ICF and SNF beds previously approved through certificate of need but not yet licensed.

(3) ICF and SNF beds in designated units in hospitals in the county.

c. The statistical calculation of bed need shall serve as a guideline for the department in reviewing need for the proposed long-term care beds. Other factors that may be considered by the department include but are not limited to:

(1) The availability and utilization of other ICF and SNF services in the county or within an applicant’s service area.

(2) The availability and utilization of other long-term care services in nearby hospitals, such as skilled care available through the swing bed program.

(3) The availability of supportive living arrangements that may or may not be licensed as an RCF.

(4) The availability of home health and other in-home services.

(5) The availability of other services to the elderly.

(6) The availability of ICF and SNF services in neighboring counties.

(7) Utilization by out-of-state residents of facilities in counties bordering other states, where an applicant provides evidence that in-migration of long-term care patients exceeds out-migration to the bordering state.

(8) Programs and services directed at special populations whose needs cannot otherwise be met or whose needs cannot be met cost-effectively at other facilities.

*d.* In documenting need for a project, an applicant shall identify the service area and target population, including a description of the methodology used by the applicant in determining need for the requested beds and the expected sources of referrals. The applicant shall document that the number of beds requested is appropriate to address the identified need. The applicant shall also identify how the target population is currently being cared for and what hardship is being experienced by the absence of the proposed beds.

**124.4(4) *Quality.*** (Iowa Code section 135.63(1) “i” and “k”) An applicant shall document that the applicant has contacted the health and safety division of the department of inspections, appeals, and licensing to conform with physical standards, staffing requirements, and other licensing requirements to assess the potential for provision of quality care at the facility. When necessary, the applicant shall attempt to arrange an on-site visit to the facility to determine compliance with physical requirements and shall provide documentation of this site visit or attempts to arrange such a site visit.

**124.4(5) *Continuity.*** (Iowa Code section 135.63(1) “g,” “h,” and “k”)

*a.* An applicant shall document the relationship of the facility’s proposed services to other health and long-term care services in the community, such as physician and hospital services, habilitation, rehabilitation, transportation or other services. The facility should be capable of providing or arranging for the provision of a continuum of long-term care services.

*b.* A facility should be capable of providing or arranging for the provision of a comprehensive program of coordinated patient services. An applicant shall provide evidence of contracts for services, appropriate staffing patterns and ratios, and licensure of personnel as necessary.

**124.4(6) *Accessibility and acceptability.*** (Iowa Code section 135.63(1) “c” and “d”)

*a.* Population subgroups that have traditionally been underserved, such as adolescents, the elderly, women, racial minorities, mentally ill, intellectually disabled, and developmentally disabled, should be considered when planning for or reviewing long-term care facilities.

*b.* An applicant shall document to what extent Medicaid patients will be served by the proposed beds, using past Medicaid utilization as an indicator or, in the case of a new facility, projecting anticipated Medicaid utilization.

**124.4(7) *Costs and financial feasibility.*** (Iowa Code section 135.63(1) “e,” “f,” “i,” and “p”)

*a.* An applicant shall identify capital and operating costs associated with the project, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

*b.* Construction costs shall be in line with construction costs of other similar projects.

*c.* An applicant shall provide budgets for the first three years of operation, including documentation of all assumptions used. The budget shall include anticipated sources of revenue, including the percentage of revenue from private pay, Medicaid, Medicare and other patient revenues.

*d.* Proposed charges per patient day should be justifiable when compared to current charges of other similarly licensed facilities in an applicant’s service area or other similar facilities elsewhere in the state. If charges are significantly higher or lower, the applicant shall provide a description of proposed programs or services that explain the difference in charges.

These rules are intended to implement Iowa Code section 135.71.

#### **441—124.5(135) MRI services standards.**

**124.5(1) *Purpose and scope.***

*a.* These standards are measures of some of those criteria in Iowa Code section 135.63(1) “a” through “q.” Criteria that are measured by a standard are cited in parentheses following each standard.

*b.* Certificate of need applications that are to be evaluated against these standards include:

- (1) Proposals to commence or expand the capacity of magnetic resonance imaging services.
- (2) Proposals to replace a magnetic resonance imaging unit.
- (3) Any other applications that relate to magnetic resonance imaging.

**124.5(2) *Definitions.*** The following definitions apply to the terms used in this rule:

“Area” means the community or a metropolitan statistical area (as defined by the U.S. Office of Management and Budget and used by the U.S. Census Bureau).

“Computed tomography” or “CT” means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

“CT procedure” means a CT study of a single site of anatomic interest during an individual patient visit.

“Magnetic resonance imaging” or “MRI” means a diagnostic modality that employs a combination of magnetic and radio frequency fields and computers to produce images of body organs and tissues.

“MRI procedure” means each discrete MRI study of one patient.

“MRI unit” means the essential equipment and facility necessary to operate one MRI system.

**124.5(3) Availability and need.** (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”)

a. An applicant in an area with no other MRI units. The applicant must document a future utilization of reasonably projected MRI procedure volume for the fiscal year period after projected installation.

b. An applicant in an area with one or more MRI units currently in operation or approved by certificate of need for operation.

(1) An applicant must meet the requirement of need described in paragraph 124.5(3) “a,” and

(2) The other MRI unit(s) within the area must have been operating at a minimum of 2,000 MRI procedures annually (or 500 in three months) or proportionately more if the MRI unit runs more than one ten-hour shift.

(3) If the annual utilization of the other MRI unit(s) within the area has been below 2,000 procedures, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the 2,000 procedure level must be demonstrated.

c. An applicant seeking to replace an MRI unit.

(1) An applicant must demonstrate that the existing MRI unit has been operating at the level of at least 3,000 procedures during the most recent annual period.

(2) If an applicant’s annual utilization has been below 2,000 procedures, the applicant must reasonably project future utilization above that level or demonstrate reasons for permanently utilizing the equipment below that level.

d. An applicant seeking to add an additional MRI unit.

(1) An applicant must demonstrate that the existing MRI unit(s) has been operating at the level of at least 3,500 procedures during the most recent annual period.

(2) An applicant must demonstrate that the demand significantly exceeds the 2,000 procedures annually.

(3) If an applicant’s annual utilization has been below 2,000 procedures, the applicant must reasonably project future utilization above that level or demonstrate reasons for permanently utilizing the equipment below that level.

**124.5(4) Quality and continuity.** (Iowa Code section 135.63(1) “g,” “h,” “i,” and “k”)

a. The proposed MRI unit should function as a component of a comprehensive inpatient or outpatient diagnostic service. The proposed MRI unit must have the following modalities on-site or through referral arrangements:

(1) Ultrasound.

(2) Computed tomography.

(3) Angiography.

(4) Nuclear medicine.

(5) Conventional radiography.

b. The proposed MRI unit must be located in a facility that has, either in-house or through referral arrangement, the resources necessary to treat most of the conditions diagnosed or confirmed by MRI. The following medical specialties must be available during MRI service hours on-site or by referral arrangements: neurology or neurosurgery, oncology and cardiology.



c. A proposal to provide a new or an expanded MRI must include satisfactory assurances that the services will be offered in a physical environment that conforms to federal standards, manufacturer's specifications, and licensing agencies' requirements.

d. An applicant must provide evidence that the proposed MRI equipment has been certified for clinical use by the U.S. Food and Drug Administration or will be operated under the approval and authority of an institutional review board whose membership is consistent with U.S. Department of Health and Human Services regulations.

e. An applicant for MRI should document that the necessary qualified staff are available to operate the proposed unit. The following minimum staff will be available to the MRI unit:

(1) A board-eligible or board-certified radiologist or any other board-eligible or board-certified licensed physician whose exclusive responsibility for at least a two-year period prior to submission of a certificate of need request has been in the acquisition and interpretation of clinical images. This individual shall have a knowledge of MRI through training, experience, or documented postgraduate education. The individual shall also have training with a functional MRI facility.

(2) Qualified engineering personnel, available to the institution during MRI service hours, with training and experience in the operation and maintenance of the MRI equipment.

(3) Diagnostic radiologic technologists or other certified technologists with expertise in CT or other cross-sectional imaging methods at a staffing level consistent with the hospital's expected MRI service volume.

(4) Other appropriate physicians shall be available during MRI service hours in clinical specialties, such as neurology or neurosurgery, oncology and cardiology.

f. An applicant shall demonstrate how emergencies within the MRI unit will be managed in conformity with accepted medical practice.

**124.5(5) Accessibility and acceptability.** (Iowa Code section 135.63(1) "c" and "d")

a. An MRI facility should have adequate scheduled hours to avoid an excessive backlog of cases and to meet the needs of the communities the scanners are meant to serve.

b. Selection of patients for clinical MRI studies must guarantee equal access to all persons regardless of insurance coverage or ability to pay.

**124.5(6) Costs and financial feasibility.** (Iowa Code section 135.63(1) "e," "f," "i," and "p")

a. An applicant shall identify capital and operating costs associated with the proposed MRI unit, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. An applicant shall provide budgets for the first three years of operation, including documentation and justification of all assumptions used.

c. An applicant must document its projected average cost per procedure and charge per procedure for the first three years. Charges for an MRI should be reasonably related to service cost and comparable to MRI charges at other facilities in the state.

d. An applicant shall demonstrate that alternatives were considered and the proposed application is the most cost-effective and will accomplish the goals of the project.

**441—124.6(135) PET services standards.**

**124.6(1) Purpose and scope.**

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1) "a" through "q." Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include:

(1) Proposals to commence or expand the capacity of positron emission tomography services.

(2) Proposals to replace a positron emission tomography unit.

(3) Any other applications that relate to positron emission tomography.

**124.6(2) Definitions.** The following definitions apply to the terms used in this rule:

"Area" means the community or a metropolitan statistical area (as defined by the U.S. Office of Management and Budget and used by the U.S. Census Bureau).

“*Computed tomography*” or “*CT*” means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

“*Cyclotron*” means an apparatus for accelerating protons or neutrons to high energies by means of a constant magnet and an oscillating electric field.

“*Magnetic resonance imaging*” or “*MRI*” means a diagnostic modality that employs a combination of magnetic and radio frequency fields and computers to produce images of body organs and tissues.

“*PET procedure*” means an image-scanning sequence derived from a single administration of PET, equated with a single injection of the tracer.

“*Positron emission tomography*” or “*PET*” means an imaging method in which positron-emitting radionuclides, which are produced either by a cyclotron or generator, and a nuclear camera are used to create pictures of organ function rather than structure.

“*Radiopharmaceutical*” means a radioactive pharmaceutical used for diagnostic or therapeutic purposes.

“*Single photon emission computed tomography*” or “*SPECT*” means a camera-based imaging system using the radionuclides in the routine practice of nuclear medicine.

**124.6(3)** *Availability and need.* (Iowa Code section 135.63(1) “c,” “d,” “e,” “g,” and “h”)

a. An applicant in an area with no other PET units.

(1) An applicant should demonstrate a reasonable potential utilization of a PET unit based on diversified inpatient and outpatient case mix thresholds, including:

1. Intracranial cases.

- Primary brain tumors: 50 per year.

- Metastasis: 100 per year.

- Cerebral vascular disease: 200 per year.

- Organic brain disease and dementia/psychiatric diagnoses (including epilepsy-seizure disorders):

500 per year.

- Spinal: 100 per year.

2. Cardiovascular cases.

- Ischemic heart disease (including acute and chronic infarction): 1,200 per year.

3. Neoplasms (head, neck, thorax (excluding heart), abdomen, pelvic, prostate and musculoskeletal): 1,300 per year.

(2) An applicant should have other diagnostic capabilities, on-site or through referral arrangements, with appropriate volumes including:

|                                                                                                           | Proposed Threshold |
|-----------------------------------------------------------------------------------------------------------|--------------------|
| Nuclear medicine imaging services                                                                         | 5,600              |
| Single photon emission computed tomography<br>(including brain, bone, liver, gallium and thallium stress) | 1,600              |
| CT                                                                                                        | 8,000              |
| MRI                                                                                                       | 2,400              |

(3) An applicant should demonstrate secondary and tertiary service capability, on-site or through referral arrangements, including cardiac surgery, cardiology, internal medicine, general surgery, hematology/oncology, neurology, pathology, thoracic surgery and psychiatry.

b. An applicant in an area with one or more PET units currently in operation or approved by the certificate of need program for operation.

Existing PET units within the area (whether basic or enhanced) should have been operating at a minimum of 1,000 PET procedures during the most recent annual period as reported to the certificate of need program according to paragraph 124.6(4) “e.”

**124.6(4)** *Quality and continuity.* (Iowa Code section 135.63(1) “g,” “h,” “i,” and “k”)

a. A proposed PET unit should function as a component of a comprehensive inpatient or outpatient diagnostic service. The proposed PET unit should have the following modalities (and capabilities) on-site or through referral arrangements:

- (1) CT.
- (2) MRI.
- (3) Nuclear medicine—cardiac, SPECT.
- (4) Conventional radiography.

b. A proposed PET unit should be located in a facility that has, either in-house or through referral arrangement, the resources necessary to treat most of the conditions diagnosed or confirmed by PET. The following medical specialties should be available during PET service hours on-site or by referral arrangements: cardiology, neurology, neurosurgery, oncology, and psychiatry.

c. A proposal to provide new or expanded PET must include satisfactory assurances that services will be offered in a physical environment that conforms to federal standards, manufacturer's specifications, and licensing agencies' requirements. The following areas are to be addressed:

- (1) Quality control and assurance of radiopharmaceutical production of generator- or cyclotron-produced agents;
- (2) Quality control and assurance of PET tomograph and associated instrumentation;
- (3) Radiation protection and shielding;
- (4) Radioactive emissions to the environment.

d. An applicant will provide evidence that the proposed PET equipment has been certified for clinical use by the U.S. Food and Drug Administration or will be operated under the approval and authority of an institutional review board whose membership is consistent with U.S. Department of Health and Human Services regulations.

e. An applicant for PET will document that the necessary qualified staff are available to operate the proposed unit. The applicant will document the PET training and experience of the staff. The following minimum staff will be available to the PET unit:

- (1) One or more nuclear medicine imaging physician(s) available to the PET unit who have been licensed by the state for the handling of medical radionuclides and whose primary responsibility for at least a one-year period prior to submission of the certificate of need application has been in acquisition and interpretation of tomographic images. This individual shall have knowledge of PET through training, experience, or documented postgraduate education. The individual shall also have training with a functional PET facility.

- (2) Qualified PET radiochemist or radiopharmacist personnel available to the facility during PET service hours with at least one year of training. The individual(s) will demonstrate experience in the testing of chemical, radiochemical, and radionuclidic purity of PET radiopharmaceutical syntheses.

- (3) Qualified engineering and physics personnel available to the facility during PET service hours with training and experience in the operation and maintenance of the PET equipment.

- (4) Qualified radiation safety personnel available to the facility at all times with training and experience in the handling of short-lived positron-emitting nuclides.

- (5) Certified nuclear medicine technologists with expertise in computed tomographic nuclear medicine imaging procedures at a staffing level consistent with the proposed center's expected PET service volume.

- (6) Other appropriate personnel should be available during PET service hours, which may include certified nuclear medicine technologists, computer programmers, nurses, and radiochemistry technicians.

f. An applicant will demonstrate how emergencies within the PET unit will be managed in conformity with accepted medical practice.

**124.6(5) Accessibility and acceptability.** (Iowa Code section 135.63(1) "c" and "d")

a. A PET facility should have adequate scheduled hours to avoid an excessive backlog of cases.

b. Selection of patients for clinical PET studies will guarantee equal access to all persons regardless of insurance coverage or ability to pay.

c. In addition to accepting patients from participating institutions, a facility performing clinical PET procedures should accept appropriate referrals from other local providers. These patients will be accommodated to the extent possible by extending the hours of service and by prioritizing patients according to standards of need and appropriateness rather than source of referral.

**124.6(6) Costs and financial feasibility.** (Iowa Code section 135.63(1) "e," "f," "i," and "p")

- a.* An applicant will identify capital and operating costs associated with a proposed PET unit, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.
- b.* An applicant will provide budgets for the first three years of operation, including documentation and justification of all assumptions used.
- c.* An applicant will document its projected average cost per procedure and charge per procedure for the first three years. Charges for PET should be reasonably related to service cost and comparable to PET charges at other facilities in the state.
- d.* An applicant should verify whether the service is eligible for reimbursement by public and private third-party payers.
- e.* An applicant should demonstrate that alternatives were considered and the proposed application is the most cost-effective and should accomplish the goals of the project.

These rules are intended to implement Iowa Code sections 135.61 through 135.78.

[Filed 5/6/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0323D**

## **IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495]**

### **Adopted and Filed**

#### **Rulemaking related to contribution rates**

The Iowa Public Employees' Retirement System (IPERS) hereby amends Chapter 4, "Employers," Iowa Administrative Code.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code chapter 97 and sections 97B.4 and 97B.15.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 97B.

#### *Purpose and Summary*

The purpose of this rulemaking is to update and implement contribution rate changes for all member classes, as required annually by the Iowa Code.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on April 1, 2026, as **ARC 0188D**. A public hearing was held on the following date(s):

- April 21, 2026

No one attended the public hearing. No public comments were received. No changes from the Notice have been made.

#### *Adoption of Rulemaking*

This rulemaking was adopted by the Acting Chief Executive Officer, Elizabeth Hennessey, on May 6, 2026.

*Fiscal Impact*

IPERS' enabling legislation requires that employer and employee contribution rates for each member class be updated every fiscal year.

*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 IPERS 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 July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Amend subrules 4.6(1) to 4.6(3) as follows:

**4.6(1)** Contribution rates for regular class members.

*a.* The following contribution rates were established by the Iowa legislature for all regular class members for the indicated periods:

|               | Effective July 1, 2007 | Effective July 1, 2008 | Effective July 1, 2009 | Effective July 1, 2010 | Effective July 1, 2011 |
|---------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| Combined rate | 9.95%                  | 10.45%                 | 10.95%                 | 11.45%                 | 13.45%                 |
| Employer      | 6.05%                  | 6.35%                  | 6.65%                  | 6.95%                  | 8.07%                  |
| Employee      | 3.90%                  | 4.10%                  | 4.30%                  | 4.50%                  | 5.38%                  |

*b.* Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rulemaking that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

|               | Effective July 1, 2021 | Effective July 1, 2022 | Effective July 1, 2023 | Effective July 1, 2024 | Effective July 1, 2025 | Effective July 1, 2026 |
|---------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| Combined rate | <del>15.73%</del>      | 15.73%                 | 15.73%                 | 15.73%                 | 15.73%                 | <u>15.73%</u>          |
| Employer      | <del>9.44%</del>       | 9.44%                  | 9.44%                  | 9.44%                  | 9.44%                  | <u>9.44%</u>           |
| Employee      | <del>6.29%</del>       | 6.29%                  | 6.29%                  | 6.29%                  | 6.29%                  | <u>6.29%</u>           |

**4.6(2)** Contribution rates for sheriffs and deputy sheriffs are as follows.

|               | Effective<br>July 1, 2021 | Effective<br>July 1, 2022 | Effective<br>July 1, 2023 | Effective<br>July 1, 2024 | Effective<br>July 1, 2025 | Effective<br>July 1,<br>2026 |
|---------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|------------------------------|
| Combined rate | <del>18.02%</del>         | 17.52%                    | 17.02%                    | 17.02%                    | 24.18%                    | <u>24.42%</u>                |
| Employer      | <del>9.01%</del>          | 8.76%                     | 8.51%                     | 8.51%                     | 11.965%                   | <u>12.085%</u>               |
| Employee      | <del>9.01%</del>          | 8.76%                     | 8.51%                     | 8.51%                     | 12.215%                   | <u>12.335%</u>               |

**4.6(3)** Contribution rates for protection occupations are as follows.

|               | Effective<br>July 1, 2021 | Effective<br>July 1, 2022 | Effective<br>July 1, 2023 | Effective<br>July 1, 2024 | Effective<br>July 1, 2025 | Effective<br>July 1,<br>2026 |
|---------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|------------------------------|
| Combined rate | <del>15.52%</del>         | 15.52%                    | 15.52%                    | 15.52%                    | 15.52%                    | <u>15.52%</u>                |
| Employer      | <del>9.31%</del>          | 9.31%                     | 9.31%                     | 9.31%                     | 9.185%                    | <u>9.185%</u>                |
| Employee      | <del>6.21%</del>          | 6.21%                     | 6.21%                     | 6.21%                     | 6.335%                    | <u>6.335%</u>                |

[Filed 5/6/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0321D**

## **REVENUE DEPARTMENT[701]**

### **Adopted and Filed**

#### **Rulemaking related to renaming of the legal services division**

The Revenue Department hereby amends Chapter 2, “Organization,” Chapter 7, “Tax Appeals, Taxpayer Representation, and Other Administrative Procedures,” Chapter 11, “Tax Administration,” and Chapter 19, “Settlements—Compromises and Abatements of Tax, Penalty, or Interest,” Iowa Administrative Code.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code sections 99G.9, 123.10 and 421.17.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code chapter 17A and sections 99G.5, 99G.7, 99G.21, 123.9, 123.10, 421.2, 421.5, 421.9, 421.14, 421.17, 422.30 and 453B.9.

#### *Purpose and Summary*

The purpose of this rulemaking is to amend several rules to align with the Department’s renaming of the Legal Services and Appeals Division to the Legal Services Division. Under this new name, the Legal Services Division will be organized into two branches, the Legal Services Section and the Enforcement Actions and Appeals Bureau, which will better reflect the core functions of each branch. By updating these rules, the Department will provide clarity and consistency for taxpayers and other members of the public who interact with services provided by the Legal Services Division. This rulemaking also amends rules 701—7.8(17A) and 701—7.10(17A), which contain outdated references to expedited hearings.

*Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on April 1, 2026, as **ARC 0174D**. A public hearing was held on the following date(s):

- April 21, 2026

No one attended the public hearing. No public comments were received.

The amendments to 701—subrules 3.7(11) and 4.7(5) were removed from the rulemaking due to the enactment of 2026 Iowa Acts, Senate File 2463, which will rescind 701—Chapters 3 and 4 effective July 1, 2026.

*Adoption of Rulemaking*

This rulemaking was adopted by the Department on May 6, 2026.

*Fiscal Impact*

This rulemaking has no fiscal impact to the State of Iowa.

*Jobs Impact*

After analysis and review of this rulemaking, no impact on jobs has been found.

*Waivers*

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 701—3.7(99G,123,421,17A).

*Review by Administrative Rules Review Committee*

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

*Effective Date*

This rulemaking will become effective on July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Amend subrule 2.5(2) as follows:

**2.5(2) Divisions.** For ease of administration, the director has organized the department into divisions and, in some instances, has organized those divisions into bureaus, sections, subsections, and units. Except for the lottery division, the director may from time to time establish, abolish, or consolidate the department's administrative divisions as the director deems necessary in order to more efficiently and effectively carry out the department's responsibilities. Such divisions may include but are not limited to:

- a. Alcohol and tax compliance.
- b. Alcohol and tax operations.
- c. Financial services.
- d. Internal services.
- e. Legal services ~~and appeals~~.
- f. Local government services.
- g. Lottery.
- h. Research and policy.

ITEM 2. Amend rule 701—7.2(421,17A) as follows:

**701—7.2(421,17A) Definitions.** Terms not defined below have the same meaning as defined in Iowa Code chapter 17A. Unless otherwise specifically stated, the terms used in these rules promulgated by the department have the meanings defined by the Act. These definitions apply to this chapter unless the text states otherwise:

“*Act*” means the Iowa administrative procedure Act.

“*Appeal*” means a dispute of a notice of assessment, refund denial, or other department action that may culminate in a contested case proceeding. “*Protest*” has the same meaning as appeal.

~~“*Appeals section*” means the section of the department designated by the director to administer the informal stage of the tax appeals process and participate in contested case proceedings for appeals before the department.~~

“*Clerk*” means the clerk of the legal services and appeals division or the clerk’s designee.

“*Department*” or “*IDR*” means the Iowa department of revenue.

“*Director*” means the director of the department or the director’s designee.

“*Division of administrative hearings*” means the division of the department of inspections, appeals, and licensing responsible for holding contested case proceedings pursuant to Iowa Code chapter 10A.

“*Enforcement actions and appeals bureau*” means the section of the legal services division of the department designated by the director to administer the informal stage of the appeals process and participate in contested case proceedings for appeals before the department.

“*Entity*” means any taxpayer other than an individual or sole proprietorship.

“*GovConnectIowa*” means the e-services portal of the department.

“*Informal stage*” means the procedures of the appeals process described in rule 701—7.10(17A).

“*Issuance*” means the date specified in the decision or order, the date of mailing of a decision, or order or date of delivery of the decision or order if service is by other means.

“*Last-known address*” means the last address associated with a taxpayer by tax type, as determined pursuant to rule 701—7.23(421).

“*Motion*” means the same as defined in Iowa Rule of Civil Procedure 1.431.

“*Party*” means the same as defined in Iowa Code section 17A.2(8) and includes intervenors.

“*Person*” means the same as defined in Iowa Code section 17A.2. “Public or private organization of any character or any other person covered by the Act other than an agency” as used in that definition includes estates, trusts, or fiduciary.

“*Petition*” means application for declaratory order; request to intervene in a declaratory order under consideration; or application for initiation of proceedings to adopt, amend or rescind a rule or document filed in licensing.

“*Pleadings*” means appeal, answer, reply or other similar document filed in a contested case proceeding, including contested cases involving no factual dispute.

“*Presiding officer*” means the person designated to preside over a proceeding involving the department. A presiding officer of a contested case involving the department will be either the director or a qualified administrative law judge appointed, pursuant to Iowa Code chapter 17A, by the division of administrative hearings established pursuant to Iowa Code section 10A.801. In cases in which the department is not a party, at the director’s discretion, the presiding officer may be the director or the director’s designee. The presiding officer of an administrative appeal is the director of the department.

“*Proceeding*” means informal, formal, and contested case proceedings.

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the director did not preside, as described in Iowa Code section 17A.15.

“*Review unit*” means the unit composed of the ~~appeals section~~ enforcement actions and appeals bureau of the legal services division of the department and any of the attorney general’s staff who have been assigned to review appeals filed by taxpayers.

“*Taxpayer interview*” means any in-person contact between an employee of the department and a taxpayer or a taxpayer’s representative that has been initiated by a department employee.

“*Taxpayer’s representative*” or “*taxpayer’s authorized representative*” means an individual authorized to practice before the department on behalf of a taxpayer under Iowa Code section 421.59;



an individual who has been named as an authorized representative on a fiduciary return of income form filed under Iowa Code section 422.14 or a tax return filed under Iowa Code chapter 450 or 450B; or for proceedings before the department, any other individual the taxpayer designates who is named on a valid power of attorney if appearing on behalf of another.

This rule is intended to implement Iowa Code chapter 17A.

ITEM 3. Amend subrule 7.3(1) as follows:

**7.3(1)** *Ways to submit an appeal, petition, or related document.* Unless otherwise specified in another rule in this chapter, a person may submit an appeal, petition, related document, or document filed during an appeal or pending petition:

- a. and b. No change.
- c. By mail to Legal Services and Appeals Division, Iowa Department of Revenue, P.O. Box 14457, Des Moines, Iowa 50306-3457.
- d. No change.

ITEM 4. Amend subparagraph **7.8(5)“b”(2)** as follows:

(2) The appeal shall substantially state in separate numbered paragraphs the following:

1. Proper allegations showing:
  - Date of department action, such as the notice of assessment or refund denial;
  - Whether the taxpayer failed to timely appeal the assessment and, if so, the date of payment and the date of filing of the refund claim;
  - Whether the appeal involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim;
  - Copies of the documented department action, such as the notice of assessment, refund claim, and refund denial letter;
  - Other items that the taxpayer wishes to bring to the attention of the department; and
  - A request for attorney fees, if applicable.
2. The type of tax, the taxable period or periods involved, and the amount in controversy.
3. Each error alleged to have been committed, listed in a separate paragraph. For each error listed, an explanation of the error and all relevant facts related to the error shall be provided.
4. Reference to any particular statute or statutes and any rule or rules involved, if known.
5. Description of records or documents that were not available or were not presented to department personnel prior to the filing of the appeal, if any. Copies of any records or documents that were not previously presented to the department shall be provided.
6. Any other matters deemed relevant and not covered in the above paragraphs.
7. ~~The desire of the taxpayer to expedite proceedings. Rule 701—7.12(17A,421) contains more details on expedited proceedings.~~
8. ~~7.~~ A statement setting forth the relief sought by the taxpayer.
9. ~~8.~~ The signature of the taxpayer or the authorized representative. If the appeal is signed by the taxpayer, the address and telephone number of the taxpayer is to be included in the signature block. If the appeal is signed by an authorized representative, the address and telephone number of the authorized representative is to be included in the signature block. Appeals submitted by an authorized representative must have a valid IDR power of attorney form or representative certification form, as applicable in accordance with rule 701—8.8(17A,22,421,422), on file with the department, or one should be included with the appeal.

ITEM 5. Amend rule 701—7.9(17A) as follows:

**701—7.9(17A) Resolution of tax liability.** In the event that a proper appeal has been filed, other department personnel, when authorized by the ~~appeals section~~ enforcement actions and appeals bureau, have the authority to discuss the resolution of any matter in the appeal either with the taxpayer or the taxpayer's representative. The personnel shall report their activities in this regard to the ~~appeals section~~ enforcement actions and appeals bureau, and the ~~section bureau~~ shall be authorized to approve or reject any recommendations made by the appropriate personnel to resolve an appeal.

This rule is intended to implement Iowa Code chapter 17A.

ITEM 6. Amend rule 701—7.10(17A) as follows:

**701—7.10(17A) Informal stage of the tax appeals process.** When an appeal is filed, the parties are encouraged to utilize the informal procedures described in this rule to reach a resolution between the parties without the necessity of initiating contested case proceedings. That resolution may be the granting of the appeal in full or in part, the denial of the appeal in full or in part, or an agreement to settle the matter. Unless, in accordance with rule 701—7.12(17A,421), the taxpayer demands a contested case proceeding ~~or an expedited hearing is agreed to~~ or the department waives informal procedures upon notification to the taxpayer, such informal procedures will be initiated as herein provided upon the filing of a proper appeal.

**7.10(1)** ~~Appeals section~~ *Enforcement actions and appeals bureau review.* After an appeal is filed, the review unit, subject to the control of the director or the division administrator of the legal services ~~and appeals~~ division, will:

*a. to e.* No change.

**7.10(2) to 7.10(4)** No change.

**7.10(5) Settlements.** Only the director, a deputy director, the division administrator of the legal services ~~and appeals~~ division, or another person designated in writing by the director may approve and sign settlements of appeals. If a settlement is reached during informal procedures, a closing order stating that a settlement was reached by the parties and that the case is terminated shall be issued by the director and provided to all parties.

This rule is intended to implement Iowa Code section 17A.10.

ITEM 7. Amend rule 701—11.7(422,453B) as follows:

**701—11.7(422,453B) Jeopardy assessments.**

**11.7(1)** No change.

**11.7(2)** *Request for bond.*

*a.* In the event a taxpayer seeks to post a bond in lieu of summary collection of a jeopardy assessment, pending final determination of the amount of tax legally due, the taxpayer must file a Jeopardy Assessment Bond Request Form, available on the department's website, with the clerk of the ~~appeals section~~ legal services division for the department. The department will accept or reject the bond request, in writing, within ten days. If the department does not respond within ten days, the bond request is deemed rejected. The department is not required to accept bond requests. If the department accepts the bond request, the clerk of the ~~appeals section~~ legal services division for the department shall be notified. The approval is conditioned upon the taxpayer's posting the bond in accordance with this rule.

*b.* Bond requests may be made any time after a timely appeal of the jeopardy assessment has been filed with the department in accordance with 701—Chapter 7, except that any bond request whereby the taxpayer seeks to postpone a scheduled sale of assets seized by or on behalf of the department must be filed with the clerk of the ~~appeals section~~ legal services division for the department no later than ten days from the date on which notice of the sale was mailed to, or otherwise served upon, the taxpayer. Portions of an assessment that are undisputed must be paid in full at the time a bond request is filed.

**11.7(3)** No change.

**11.7(4)** *Type of bond.*

*a.* The bond shall be payable to the department for the use of the state of Iowa and shall be conditioned upon the full payment of the tax, penalty, interest, or fees that are found to be due which remain unpaid upon the resolution of the contested case proceedings up to the amount of the bond.

*b.* A personal bond, without a surety, is only permitted if the taxpayer posts with the clerk of the ~~appeals section~~ legal services division for the department, cash, a cashier's check, a certificate of deposit, or other marketable securities which are approved by the department with a readily ascertainable value which is equal in value to the total amount of the bond required. If a surety bond is posted, the surety on the bond may be either personal or corporate. The provisions of Iowa Code chapter 636 relating to

personal and corporate sureties shall govern to the extent not inconsistent with the provisions of this subrule.

**11.7(5) to 11.7(7)** No change.

This rule is intended to implement Iowa Code sections 422.30 and 453B.9.

ITEM 8. Amend rule 701—19.3(421) as follows:

**701—19.3(421) Settlement procedures and limitations, generally.**

**19.3(1)** No change.

**19.3(2)** *Which type of settlement to seek.* Different types of settlements require different forms and procedures. Procedures for abatement, offer in compromise, and voluntary disclosure agreements are described in specific rules below. For matters currently under appeal pursuant to 701—Chapter 7, settlement requests must be submitted to the ~~appeals section~~ enforcement actions and appeals bureau of the legal services ~~and appeals~~ division in accordance with ~~701—subrule 7.11(5)~~ 701—subrule 7.10(5). For matters currently under audit, settlement requests must be submitted to the department employee assigned to the audit.

**19.3(3)** *Who may authorize a department settlement.* Only the director, the deputy director, or the division administrator of the legal services ~~and appeals~~ division may approve and sign settlements under this chapter unless otherwise specified in rule or designated by the director.

**19.3(4)** No change.

ITEM 9. Amend subrule 19.4(4) as follows:

**19.4(4)** *Review of requests.*

- a. After the application has been submitted, it will be reviewed by department staff.
- b. Additional information may be requested to assist the department in its review.
- c. A letter will be issued to the applicant notifying the applicant of the decision to grant, deny or partially grant the abatement request. The department's decision on an abatement application will only be contained in a formal determination letter.
- d. Applicants whose applications are granted in part will receive an agreement describing the terms of the partially granted abatement request and must sign and return that agreement to the department in order to receive the partially granted abatement.
- e. Decisions to accept an abatement request in full or in part for doubt as to liability may be approved by the bureau chief of the compliance ~~section of the tax management~~ division or another staff member designated by the director.
- f. Decisions to accept an abatement request to promote effective tax administration may only be approved by the director, the deputy director, or the division administrator of the legal services ~~and appeals~~ division.

ITEM 10. Amend rule 701—19.5(421) as follows:

**701—19.5(421) Offers in compromise.**

**19.5(1) to 19.5(3)** No change.

**19.5(4)** *Review of requests.*

- a. to d. No change.
- e. Decisions to enter into an offer in compromise must be approved by the bureau chief of the central collections unit, the director, the deputy director, the division administrator of the legal services ~~and appeals~~ division, or another staff member designated by the director.

**19.5(5)** No change.

ITEM 11. Amend subrule 19.6(8) as follows:

**19.6(8)** *Commencement of the voluntary disclosure agreement.* The voluntary agreement commences on the date the voluntary disclosure agreement is fully executed by all parties or another date specified by the agreement. Execution of the agreement is complete when the agreement is executed by the taxpayer or taxpayers and the division administrator of or a bureau chief of within the compliance ~~section of the tax management~~ division or another staff member designated by the director. Prior to the

execution of the voluntary disclosure agreement by the taxpayer and the department, the taxpayer is not protected from the department's regular audit process if the identity of the taxpayer, as an applicant, is unknown to the department. However, if the department has knowledge of the taxpayer's identity, as an applicant, the department will not take audit action against the taxpayer during the voluntary disclosure process. If a voluntary disclosure agreement is not reached, the department may assess tax, penalty, and interest as provided by law at the time the identity of the applicant becomes known to the department.

[Filed 5/6/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.

**ARC 0322D**

## **VETERINARY MEDICINE BOARD[811]**

### **Adopted and Filed**

#### **Rulemaking related to civil penalties**

The Board of Veterinary Medicine hereby amends Chapter 10, "Discipline," Iowa Administrative Code.

#### *Legal Authority for Rulemaking*

This rulemaking is adopted under the authority provided in Iowa Code section 169.5.

#### *State or Federal Law Implemented*

This rulemaking implements, in whole or in part, Iowa Code section 169.13.

#### *Purpose and Summary*

The amendment implements changes made during the 2025 Legislative Session that provided the Board with the ability to issue civil penalties up to \$10,000.

#### *Public Comment and Changes to Rulemaking*

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on March 18, 2026, as **ARC 0124D**. No public comments were received. No changes from the Notice have been made.

#### *Adoption of Rulemaking*

This rulemaking was adopted by the Board on April 30, 2026.

#### *Fiscal Impact*

This rulemaking has no fiscal impact to the State of Iowa.

#### *Jobs Impact*

After analysis and review of this rulemaking, no impact on jobs has been found.

#### *Waivers*

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Board for a waiver of the discretionary provisions, if any, pursuant to 811—Chapter 14.

*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 July 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Amend rule 811—10.6(17A,169,272C), introductory paragraph, as follows:

**811—10.6(17A,169,272C) Grounds for discipline and principles of veterinary medical ethics.** The provisions of Iowa Code sections 272C.10 and 169.13 are incorporated by reference. The board has established grounds for discipline and principles of ethics for veterinary medicine. Without regard as to whether the board has determined that an injury has occurred, the board may impose any of the disciplinary sanctions set forth in rule 811—10.7(17A,169,272C), including civil penalties in an amount not to exceed ~~\$1,000~~ \$10,000, when the board determines that the credential holder is guilty of any of the following acts or offenses:

[Filed 5/5/26, effective 7/1/26]

[Published 5/27/26]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/27/26.