

HUMAN SERVICES DEPARTMENT[441]

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 177
“In-Home Health-Related Care”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249.3(2)

State or federal law(s) implemented by the rulemaking: Iowa Code section 249.3(2)

Public Hearing

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

May 5, 2026
10 a.m.

Microsoft Teams
Meeting ID: 272 564 125 499 36
Passcode: fJ693L5F

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:

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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 As a result, the Department standardized terminology, removed provisions that were no longer valid, and reduced restrictive terms.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.

Analysis of Impact

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

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

There are no costs associated with this proposed rulemaking.

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

Individuals who receive in-home health-related care and their families will benefit from the guidance in this proposed rulemaking.

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

• **Quantitative description of impact:**

In SFY 2025, there was a monthly average of 184 individuals served under the program. Expenditures under the program averaged \$85,223 per month, with a total of \$1,022,676 expended.

• **Qualitative description of impact:**

The cost of reimbursing a family member to provide in-home care is significantly less than utilizing in-home agency providers, adult day centers, or facility-based care. This model also reinforces consumer choice and person-centered practices.

3. Costs to the State:

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

The Department incurs personnel and other administrative costs associated with implementing the proposed chapter.

• **Anticipated effect on State revenues:**

Because the Department is not making any substantive changes to the program in this proposed chapter, there will be no impact on State revenues.

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

Iowa Code section 249.3(2)“a”(1) permits the Department to define and establish the information contained in these proposed rules.

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:**

Iowa Code section 249.3(2)“a”(1) permits the Department to define and establish the information contained in these proposed rules.

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 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 365th 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. IHHRC 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).