MEDICAL ASSISTANCE

Footnotes

See Iowa Acts for special provisions relating to medical
assistance reimbursements in a given year

Obligation to pay for costs of service rendered
prior to July 1, 1997; disputed billings;
2001 Acts, ch 155, §12, 13
Modified price-based case-mix reimbursement
for nursing facilities; 2001 Acts, ch 192, §4;
2002 Acts, ch 1172, §2; 2003 Acts, ch 112, § 9;
2003 Acts, ch 175, § 50; 2003 Acts, ch 179, § 165;
2004 Acts, ch 1175, § 154; 2005 Acts, ch 175, §31
Medical assistance utilization review;
2003 Acts, ch 112, § 10
Chronic disease management pilot project; 2003 Acts, ch 112, §12;
2003 Acts, ch 179, § 166, 167; 2004 Acts, ch 1175, §119
Health insurance data match program;
2004 Acts, ch 1175, § 119, 162; 2005 Acts, ch 175, §9
Prescription drug copayments; 2005 Acts, ch 167, §42, 66
Conditions for qualification of state medical institution for payments
under Medicare and Medicaid waiver; workgroup to develop plan
by July 1, 2007, regarding housing and services for persons with
mental retardation or developmental disabilities; §219.1

249A.1 Title.

This chapter may be cited as the *"Medical Assistance Act"*.

[C62, 66, 71, 73, 75, 77, 79, 81, § 249A.1]

249A.2 Definitions.

As used in this chapter:

1. *"Additional medical assistance"* means payment of all or part of the costs of any or all of the care and services authorized to be provided by Title XIX of the federal Social Security Act, section 1905(a), paragraphs (6), (7), (9) to (16), and (18), as codified in 42 U.S.C. § 1396d(a), pars. (6), (7), (9) to (16), and (18).

2. *"Department"* means the department of human services.

3. *"Director"* means the director of human services.

4. *"Discretionary medical assistance"* means medical assistance or additional medical assistance provided to individuals whose income and resources are in excess of eligibility limitations but are insufficient to meet all of the costs of necessary medical care and services, provided that if the assistance includes services in institutions for mental diseases or intermediate care facilities for persons with mental retardation, or both, for any group of such individuals, the assistance also includes for all covered groups of such individuals at least the care and services enumerated in Title XIX of the federal Social Security Act, section 1905(a), paragraphs (1) through (5), and (17), as codified in 42 U.S.C. § 1396d(a), pars. (1) through (5), and (17), or any seven of

the care and services enumerated in Title XIX of the federal Social Security Act, section 1905(a), paragraphs (1) through (7) and (9) through (18), as codified in 42 U.S.C. § 1396d(a), pars. (1) through (7), and (9) through (18).

5. *"Family investment program"* means the family investment program eligibility requirements under chapter 239B, except to the extent federal law requires application of the eligibility requirements under chapter 239, Code 1997, as in effect on July 16, 1996.

6. *"Group health plan cost sharing"* means payment under the medical assistance program of a premium, a coinsurance amount, a deductible amount, or any other cost sharing obligation for a group health plan as required by Title XIX of the federal Social Security Act, section 1906, as codified in 42 U.S.C. § 1396e.

7. *"Medical assistance"* means payment of all or part of the costs of the care and services required to be provided by Title XIX of the federal Social Security Act, section 1905(a), paragraphs (1) through (5), and (17), as codified in 42 U.S.C. § 1396d(a), pars. (1) through (5), and (17).

8. *"Medicare cost sharing"* means payment under the medical assistance program of a premium, a coinsurance amount, or a deductible amount for federal Medicare as provided by Title XIX of the federal Social Security Act, section 1905(p)(3), as codified in 42 U.S.C. § 1396d(p)(3).

9. *"Provider"* means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to recipients under this chapter.

10. *"Recipient"* means a person who receives medical assistance under this chapter.

11. *"Retained life estate"* means any of the following:

a. A life estate created by the recipient or recipient's spouse, in which either the recipient or the recipient's spouse held any interest in the property at the time of the creation of the life estate.

b. A life estate created for the benefit of the recipient or the recipient's spouse in property in which either the recipient or the recipient's spouse held any interest in the property within five years prior to the creation of the life estate.

[C62, 66, 71, 73, 75, 77, 79, 81, § 249A.2]

83 Acts, ch 96, § 157, 159; 84 Acts, ch 1297, § 2; 89 Acts, ch 104, § 1; 90 Acts, ch 1039, § 15; 91 Acts, ch 107, §11; 91 Acts, ch 158, § 1, 2; 93 Acts, ch 54, §5; 96 Acts, ch 1129, § 113; 97 Acts, ch 41, § 25; 2002 Acts, ch 1086, §1, 21

249A.3 Eligibility.

The extent of and the limitations upon eligibility for assistance under this chapter is prescribed by this section, subject to federal requirements, and by laws appropriating funds for assistance provided pursuant to this chapter.

1. Medical assistance shall be provided to, or on behalf of, any individual or family residing in the state of Iowa, including those residents who are temporarily absent from the state, who:

a. Is a recipient of federal supplemental security income or who would be eligible for federal supplemental security income if living in their own home.

b. Is an individual who is eligible for the family investment program or is an individual who would be

eligible for unborn child payments under the family investment program, as authorized by Title IV-A of the federal Social Security Act, if the family investment program provided for unborn child payments during the entire pregnancy.

c. Was a recipient of one of the previous categorical assistance programs as of December 31, 1973, and would continue to meet the eligibility requirements for one of the previous categorical assistance programs as the requirements existed on that date.

d. Is a child up to one year of age who was born on or after October 1, 1984, to a woman receiving medical assistance on the date of the child's birth, who continues to be a member of the mother's household, and whose mother continues to receive medical assistance.

e. Is a pregnant woman whose pregnancy has been medically verified and who qualifies under either of the following:

(1) The woman would be eligible for cash assistance under the family investment program, if the child were born and living with the woman in the month of payment.

(2) The woman meets the income and resource requirements of the family investment program, provided the unborn child is considered a member of the household, and the woman's family is treated as though deprivation exists.

f. Is a child who is less than seven years of age and who meets the income and resource requirements of the family investment program.

g. (1) Is a child who is one through five years of age as prescribed by the federal Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, whose income is not more than one hundred thirty-three percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

(2) Is a child who has attained six years of age but has not attained nineteen years of age, whose income is not more than one hundred thirty-three percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

h. Is a woman who, while pregnant, meets eligibility requirements for assistance under the federal Social Security Act, section 1902(l), and continues to meet the requirements except for income. The woman is eligible to receive assistance until sixty days after the date pregnancy ends.

i. Is a pregnant woman who is determined to be presumptively eligible by a health care provider qualified under the federal Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9407. The woman is eligible for ambulatory prenatal care assistance until the last day of the month following the month of the presumptive eligibility determination. If the department receives the woman's medical assistance application by the last day of the month following the month of the presumptive eligibility determination, the woman is eligible for ambulatory prenatal care assistance until the department actually determines the woman's eligibility or ineligibility for medical assistance. The costs of services provided during the presumptive eligibility period shall be paid by the medical assistance program for those persons who are determined to be ineligible through the regular eligibility determination process.

j. Is a pregnant woman or infant less than one year of age whose income does not exceed the federally prescribed percentage of the poverty level in accordance with the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302.

k. Is a pregnant woman or infant whose income is more than the limit prescribed under the federal Medicare

Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, but not more than two hundred percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

l. Is an infant whose income is not more than two hundred percent of the federal poverty level, as defined by the most recently revised income guidelines published by the United States department of health and human services.

m. Is a child for whom adoption assistance or foster care maintenance payments are paid under Title IV-E of the federal Social Security Act.

n. Is an individual or family who is ineligible for the family investment program because of requirements that do not apply under Title XIX of the federal Social Security Act.

o. Was a federal supplemental security income or a state supplementary assistance recipient, as defined by section 249.1, and a recipient of federal social security benefits at one time since August 1, 1977, and would be eligible for federal supplemental security income or state supplementary assistance but for the increases due to the cost of living in federal social security benefits since the last date of concurrent eligibility.

p. Is an individual whose spouse is deceased and who is ineligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, due to the elimination of the actuarial reduction formula for federal social security benefits under the federal Social Security Act and subsequent cost of living increases.

q. Is an individual who is at least sixty years of age and is ineligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, because of receipt of social security widow or widower benefits and is not eligible for federal Medicare, part A coverage.

r. Is an individual with a disability, and is at least eighteen years of age, who receives parental social security benefits under the federal Social Security Act and is not eligible for federal supplemental security income or state supplementary assistance, as defined by section 249.1, because of the receipt of the social security benefits.

s. Is an individual who is no longer eligible for the family investment program due to earned income. The department shall provide transitional medical assistance to the individual for the maximum period allowed for federal financial participation under federal law.

t. Is an individual who is no longer eligible for the family investment program due to the receipt of child or spousal support. The department shall provide transitional medical assistance to the individual for the maximum period allowed for federal financial participation under federal law.

2. Medical assistance may also, within the limits of available funds and in accordance with section 249A.4, subsection 1, be provided to, or on behalf of, other individuals and families who are not excluded under subsection 5 of this section and whose incomes and resources are insufficient to meet the cost of necessary medical care and services in accordance with the following order of priorities:

a. As allowed under 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII), individuals with disabilities, who are less than sixty-five years of age, who are members of families whose income is less than two hundred fifty percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, who have earned income and who are eligible for medical assistance or additional medical assistance under this section if earnings are disregarded. As allowed by 42 U.S.C. § 1396a(r)(2), unearned income shall also be disregarded in determining whether an individual is eligible for assistance under this paragraph. For the purposes of determining the amount of an individual's resources

under this paragraph and as allowed by 42 U.S.C. § 1396a(r)(2), a maximum of ten thousand dollars of available resources shall be disregarded, and any additional resources held in a retirement account, in a medical savings account, or in any other account approved under rules adopted by the department shall also be disregarded. Individuals eligible for assistance under this paragraph, whose individual income exceeds one hundred fifty percent of the official poverty guidelines published by the United States department of health and human services for an individual, shall pay a premium. The amount of the premium shall be based on a sliding fee schedule adopted by rule of the department and shall be based on a percentage of the individual's income. The maximum premium payable by an individual whose income exceeds one hundred fifty percent of the official poverty guidelines shall be commensurate with the cost of state employees' group health insurance in this state.

b. As provided under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, women who meet all of the following criteria:

(1) Are not described in 42 U.S.C. § 1396a(a)(10)(A)(i).

(2) Have not attained age sixty-five.

(3) Have been screened for breast and cervical cancer under the United States centers for disease control and prevention breast and cervical cancer early detection program established under 42 U.S.C. § 300k et seq., in accordance with the requirements of 42 U.S.C. § 300n, and need treatment for breast or cervical cancer. A woman is considered screened for breast and cervical cancer under this subparagraph if the woman is screened by any provider or entity, and the state grantee of the United States centers for disease control and prevention funds under Title XV of the federal Public Health Services Act has elected to include screening activities by that provider or entity as screening activities pursuant to Title XV of the federal Public Health Services Act. This screening includes but is not limited to breast or cervical cancer screenings or related diagnostic services provided by family planning or community health centers and breast cancer screenings funded by the Susan G. Komen foundation which are provided to women who meet the eligibility requirements established by the state grantee of the United States centers for disease control and prevention funds under Title XV of the federal Public Health Services Act.

(4) Are not otherwise covered under creditable coverage as defined in 42 U.S.C. § 300gg(c).

A woman who meets the criteria of this paragraph shall be presumptively eligible for medical assistance.

c. Individuals who are receiving care in a hospital or in a basic nursing home, intermediate nursing home, skilled nursing home or extended care facility, as defined by section 135C.1, and who meet all eligibility requirements for federal supplemental security income except that their income exceeds the allowable maximum therefor, but whose income is not in excess of the maximum established by subsection 4 for eligibility for medical assistance and is insufficient to meet the full cost of their care in the hospital or health care facility on the basis of standards established by the department.

d. Individuals under twenty-one years of age living in a licensed foster home, or in a private home pursuant to a subsidized adoption arrangement, for whom the department accepts financial responsibility in whole or in part and who are not eligible under subsection 1.

e. Individuals who are receiving care in an institution for mental diseases, and who are under twenty-one years of age and whose income and resources are such that they are eligible for the family investment program, or who are sixty-five years of age or older and who meet the conditions for eligibility in paragraph *"a"* of this subsection.

f. Individuals and families whose incomes and resources are such that they are eligible for federal supplemental security income or the family investment program, but who are not actually receiving such

public assistance.

g. Individuals who are receiving state supplementary assistance as defined by section 249.1 or other persons whose needs are considered in computing the recipient's assistance grant.

h. Individuals under twenty-one years of age who qualify on a financial basis for, but who are otherwise ineligible to receive assistance under the family investment program.

i. Individuals and families who would be eligible under subsection 1 or 2 of this section except for excess income or resources, or a reasonable category of those individuals and families.

j. Individuals who have attained the age of twenty-one but have not yet attained the age of sixty-five who qualify on a financial basis for, but who are otherwise ineligible to receive, federal supplemental security income or assistance under the family investment program.

Notwithstanding the provisions of this subsection establishing priorities for individuals and families to receive medical assistance, the department may determine within the priorities listed in this subsection which persons shall receive medical assistance based on income levels established by the department, subject to the limitations provided in subsection 4.

3. Additional medical assistance may, within the limits of available funds and in accordance with section 249A.4, subsection 1, be provided to, or on behalf of, either:

a. Only those individuals and families described in subsection 1 of this section; or

b. Those individuals and families described in both subsections 1 and 2.

4. Discretionary medical assistance, within the limits of available funds and in accordance with section 249A.4, subsection 1, may be provided to or on behalf of those individuals and families described in subsection 2, paragraph *"i"* of this section.

5. Assistance shall not be granted under this chapter to:

a. An individual or family whose income, considered to be available to the individual or family, exceeds federally prescribed limitations.

b. An individual or family whose resources, considered to be available to the individual or family, exceed federally prescribed limitations.

5A. In determining eligibility for children under subsection 1, paragraphs *"b"*, *"f"*, *"g"*, *"j"*, *"k"*, *"n"*, and *"s"*; subsection 2, paragraphs *"c"*, *"e"*, *"f"*, *"h"*, and *"i"*; and subsection 5, paragraph *"b"*, all resources of the family, other than monthly income, shall be disregarded.

6. In determining the eligibility of an individual for medical assistance under this chapter, for resources transferred to the individual's spouse before October 1, 1989, or to a person other than the individual's spouse before July 1, 1989, the department shall include, as resources still available to the individual, those nonexempt resources or interests in resources, owned by the individual within the preceding twenty-four months, which the individual gave away or sold at less than fair market value for the purpose of establishing eligibility for medical assistance under this chapter.

a. A transaction described in this subsection is presumed to have been for the purpose of establishing eligibility for medical assistance under this chapter unless the individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

b. The value of a resource or an interest in a resource in determining eligibility under this subsection is the fair market value of the resource or interest at the time of the transaction less the amount of any compensation received.

c. If a transaction described in this subsection results in uncompensated value exceeding twelve thousand dollars, the department shall provide by rule for a period of ineligibility which exceeds twenty-four months and has a reasonable relationship to the uncompensated value above twelve thousand dollars.

7. In determining the eligibility of an individual for medical assistance under this chapter, the department shall consider resources transferred to the individual's spouse on or after October 1, 1989, or to a person other than the individual's spouse on or after July 1, 1989, and prior to August 11, 1993, as provided by the federal Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 303(b), as amended by the federal Family Support Act of 1988, Pub. L. No. 100-485, § 608(d)(16)(B), (D), and the federal Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6411(e)(1).

8. Medicare cost sharing shall be provided in accordance with the provisions of Title XIX of the federal Social Security Act, section 1902(a)(10)(E), as codified in 42 U.S.C. § 1396a(a)(10)(E), to or on behalf of an individual who is a resident of the state or a resident who is temporarily absent from the state, and who is a member of any of the following eligibility categories:

a. A qualified Medicare beneficiary as defined under Title XIX of the federal Social Security Act, section 1905(p)(1), as codified in 42 U.S.C. § 1396d(p)(1).

b. A qualified disabled and working person as defined under Title XIX of the federal Social Security Act, section 1905(s), as codified in 42 U.S.C. § 1396d(s).

c. A specified low-income Medicare beneficiary as defined under Title XIX of the federal Social Security Act, section 1902(a)(10)(E)(iii), as codified in 42 U.S.C. § 1396a(a)(10)(E)(iii).

d. An additional specified low-income Medicare beneficiary as described under Title XIX of the federal Social Security Act, section 1902(a)(10)(E)(iv)(I), as codified in 42 U.S.C. § 1396a(a)(10)(E)(iv)(I).

e. An additional specified low-income Medicare beneficiary described under Title XIX of the federal Social Security Act, section 1902(a)(10)(E)(iv)(II), as codified in 42 U.S.C. § 1396a(a)(10)(E)(iv)(II).

9. Beginning October 1, 1990, in determining the eligibility of an institutionalized individual for assistance under this chapter, the department shall establish a minimum community spouse resource allowance amount of twenty-four thousand dollars to be retained for the benefit of the institutionalized individual's community spouse in accordance with the federal Social Security Act, section 1924(f) as codified in 42 U.S.C. § 1396r-5(f).

10. Group health plan cost sharing shall be provided as required by Title XIX of the federal Social Security Act, section 1906, as codified in 42 U.S.C. § 1396e.

11. *a.* In determining the eligibility of an individual for medical assistance, the department shall consider transfers of assets made on or after August 11, 1993, as provided by the federal Social Security Act, section 1917(c), as codified in 42 U.S.C. § 1396p(c).

b. The department shall exercise the option provided in 42 U.S.C. § 1396p(c) to provide a period of ineligibility for medical assistance due to a transfer of assets by a noninstitutionalized individual or the spouse of a noninstitutionalized individual. For noninstitutionalized individuals, the number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all assets transferred by the individual or the individual's spouse on or after the look-back date specified in 42 U.S.C. § 1396p(c)(1)(B)(i),

divided by the average monthly cost to a private patient for nursing facility services in Iowa at the time of application. The services for which noninstitutionalized individuals shall be made ineligible shall include any long-term care services for which medical assistance is otherwise available. Notwithstanding section 17A.4, the department may adopt rules providing a period of ineligibility for medical assistance due to a transfer of assets by a noninstitutionalized individual or the spouse of a noninstitutionalized individual without notice of opportunity for public comment, to be effective immediately upon filing under section 17A.5, subsection 2, paragraph *"b"*, subparagraph (1).

c. A disclaimer of any property, interest, or right pursuant to section 633E.5 constitutes a transfer of assets for the purpose of determining eligibility for medical assistance in an amount equal to the value of the property, interest, or right disclaimed.

d. Failure of a surviving spouse to take an elective share pursuant to chapter 633, division V, constitutes a transfer of assets for the purpose of determining eligibility for medical assistance to the extent that the value received by taking an elective share would have exceeded the value of the inheritance received under the will.

12. In determining the eligibility of an individual for medical assistance, the department shall consider income or assets relating to trusts or similar legal instruments or devices established on or before August 10, 1993, as available to the individual, in accordance with the federal Comprehensive Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, § 9506(a), as amended by the federal Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9435(c).

13. In determining the eligibility of an individual for medical assistance, the department shall consider income or assets relating to trusts or similar legal instruments or devices established after August 10, 1993, as available to the individual, in accordance with 42 U.S.C. § 1396p(d) and sections 633C.2 and 633C.3.

[C62, 66, § 249A.3, 249A.4; C71, 73, 75, 77, 79, 81, § 249A.3; 81 Acts, ch 7, § 15, ch 82, § 1]

84 Acts, ch 1297, § 35; 85 Acts, ch 146, § 2; 89 Acts, ch 104, § 24; 89 Acts, ch 304, § 202; 90 Acts, ch 1258, § 6; 90 Acts, ch 1270, § 48; 91 Acts, ch 158, § 3, 4; 92 Acts, ch 1043, § 4; 92 Acts, 2nd Ex, ch 1001, § 420; 93 Acts, ch 97, §37; 94 Acts, ch 1120, §1, 8, 9, 16; 95 Acts, ch 68, § 1; 96 Acts, ch 1129, § 64; 97 Acts, ch 41, §2628; 98 Acts, ch 1218, §77; 99 Acts, ch 94, §1; 99 Acts, ch 203, §50; 99 Acts, ch 208, §50; 2000 Acts, ch 1060, §13; 2000 Acts, ch 1221, §6; 2000 Acts, ch 1228, §41; 2001 Acts, ch 184, §9; 2003 Acts, ch 62, § 2; 2004 Acts, ch 1015, §1; 2005 Acts, ch 38, §1, 55

Footnotes

Spousal support debt for medical assistance to institutionalized
spouse; community spouse resource allowance; chapter 249B

249A.4 Duties of director.

The director shall be responsible for the effective and impartial administration of this chapter and shall, in accordance with the standards and priorities established by this chapter, by applicable federal law, by the regulations and directives issued pursuant to federal law, by applicable court orders, and by the state plan approved in accordance with federal law, make rules, establish policies, and prescribe procedures to implement this chapter. Without limiting the generality of the foregoing delegation of authority, the director is hereby specifically empowered and directed to:

1. Determine the greatest amount, duration, and scope of assistance which may be provided, and the broadest range of eligible individuals to whom assistance may effectively be provided, under this chapter within the limitations of available funds. In so doing, the director shall at least every six months evaluate the scope of

the program currently being provided under this chapter, project the probable cost of continuing a like program, and compare the probable cost with the remaining balance of the state appropriation made for payment of assistance under this chapter during the current appropriation period. After each evaluation of the scope of the program, the director shall report to the general assembly through the legislative council or in another manner as the general assembly may by resolution direct.

2. Reserved.

3. Have authority to provide for payment under this chapter of assistance rendered to any applicant prior to the date the application is filed.

4. Have authority to contract with any corporation authorized to engage in this state in insuring groups or individuals for all or part of the cost of medical, hospital, or other health care or with any corporation maintaining and operating a medical, hospital, or health service prepayment plan under the provisions of chapter 514 or with any health maintenance organization authorized to operate in this state, for any or all of the benefits to which any recipients are entitled under this chapter to be provided by such corporation or health maintenance organization on a prepaid individual or group basis.

5. May, to the extent possible, contract with a private organization or organizations whereby such organization will handle the processing of and the payment of claims for services rendered under the provisions of this chapter and under such rules and regulations as shall be promulgated by such department. The state department may give due consideration to the advantages of contracting with any organization which may be serving in Iowa as "intermediary" or "carrier" under Title XVIII of the federal Social Security Act, as amended.

6. Shall cooperate with any agency of the state or federal government in any manner as may be necessary to qualify for federal aid and assistance for medical assistance in conformity with the provisions of chapter 249, this chapter and Titles XVI and XIX of the federal Social Security Act, as amended.

7. Shall provide for the professional freedom of those licensed practitioners who determine the need for or provide medical care and services, and shall provide freedom of choice to recipients to select the provider of care and services, except when the recipient is eligible for participation in a health maintenance organization or prepaid health plan which limits provider selection and which is approved by the department. However, this shall not limit the freedom of choice to recipients to select providers in instances where such provider services are eligible for reimbursement under the medical assistance program but are not provided under the health maintenance organization or under the prepaid health plan, or where the recipient has an already established program of specialized medical care with a particular provider. The department may also restrict the recipient's selection of providers to control the individual recipient's overuse of care and services, provided the department can document this overuse. The department shall promulgate rules for determining the overuse of services, including rights of appeal by the recipient.

Advanced registered nurse practitioners licensed pursuant to chapter 152 shall be regarded as approved providers of health care services, including primary care, for purposes of managed care or prepaid services contracts under the medical assistance program. This paragraph shall not be construed to expand the scope of practice of an advanced registered nurse practitioner pursuant to chapter 152.

8. Reserved.

9. Adopt rules pursuant to chapter 17A in determining the method and level of reimbursement for all medical and health services referred to in section 249A.2, subsection 1 or 7, after considering all of the following:

a. The promotion of efficient and cost-effective delivery of medical and health services.

b. Compliance with federal law and regulations.

c. The level of state and federal appropriations for medical assistance.

d. Reimbursement at a level as near as possible to actual costs and charges after priority is given to the considerations in paragraphs *"a"*, *"b"*, and *"c"*.

10. Shall provide an opportunity for a fair hearing before the department of inspections and appeals to an individual whose claim for medical assistance under this chapter is denied or is not acted upon with reasonable promptness. Upon completion of a hearing, the department of inspections and appeals shall issue a decision which is subject to review by the department of human services.

11. In determining the medical assistance eligibility of a pregnant woman, infant, or child under the federal Social Security Act, § 1902(l), resources which are used as tools of the trade shall not be considered.

12. Reserved.

13. In implementing subsection 9, relating to reimbursement for medical and health services under this chapter, when a selected out-of-state acute care hospital facility is involved, a contractual arrangement may be developed with the out-of-state facility that is in accordance with the requirements of Titles XVIII and XIX of the federal Social Security Act. The contractual arrangement is not subject to other reimbursement standards, policies, and rate setting procedures required under this chapter.

14. A medical assistance copayment shall only be applied to those services and products specified in administrative rules of the department in effect on February 1, 1991, which under federal medical assistance requirements, are provided at the option of the state.

15. Establish appropriate reimbursement rates for community mental health centers that are accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission.

Judicial review of the decisions of the department of human services may be sought in accordance with chapter 17A. If a petition for judicial review is filed, the department of human services shall furnish the petitioner with a copy of the application and all supporting papers, a transcript of the testimony taken at the hearing, if any, and a copy of its decision.

[C62, 66, § 249A.5, 249A.10; C71, 73, 75, 77, 79, 81, § 249A.4; 82 Acts, ch 1260, § 121, 122]

83 Acts, ch 96, § 157, 159; 83 Acts, ch 153, § 12, 13; 83 Acts, ch 201, § 13; 86 Acts, ch 1245, § 2031; 89 Acts, ch 37, § 1; 89 Acts, ch 104, § 5; 89 Acts, ch 304, § 203; 90 Acts, ch 1204, § 61, 62; 90 Acts, ch 1223, § 21; 90 Acts, ch 1256, § 41; 90 Acts, ch 1264, § 34; 91 Acts, ch 97, § 32; 91 Acts, ch 158, § 5; 92 Acts, ch 1229, § 29, 30; 94 Acts, ch 1150, §1, 2; 97 Acts, ch 165, § 1; 98 Acts, ch 1181, §4; 99 Acts, ch 96, §27; 2000 Acts, ch 1029, §1, 2; 2001 Acts, ch 24, §65, 74; 2001 Acts, ch 74, §17; 2003 Acts, ch 21, §1; 2004 Acts, ch 1090, §14; 2005 Acts, ch 120, §2; 2005 Acts, ch 167, §46, 66

249A.4A Garnishment.

When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a recipient, the department may garnish the wages, salary, or other compensation of the person obligated to pay child support or may withhold amounts pursuant to chapter 252D from the income of the person obligated to pay support, and shall withhold amounts from state income tax refunds of a person obligated to pay support, to the extent necessary to reimburse the department for expenditures for medical care or expenses on behalf of a recipient if all of the following conditions apply:

1. The person is required by court or administrative order to provide medical support to a recipient.

2. The person has received payment from a third party for the costs of medical assistance to the recipient and has not used the payments to reimburse the costs of medical care or expenses.

94 Acts, ch 1171, §9

249A.4B Medical assistance advisory council.

1. A medical assistance advisory council is created to comply with 42 C.F.R. § 431.12 based on section 1902(a)(4) of the federal Social Security Act and to advise the director about health and medical care services under the medical assistance program. The council shall meet no more than quarterly. The director of public health shall serve as chairperson of the council.

2. The council shall include all of the following members:

a. The president, or the president's representative, of each of the following professional or business entities, or a member of each of the following professional or business entities, selected by the entity:

(1) The Iowa medical society.

(2) The Iowa osteopathic medical association.

(3) The Iowa academy of family physicians.

(4) The Iowa chapter of the American academy of pediatrics.

(5) The Iowa physical therapy association.

(6) The Iowa dental association.

(7) The Iowa nurses association.

(8) The Iowa pharmacy association.

(9) The Iowa podiatric medical society.

(10) The Iowa optometric association.

(11) The Iowa association of community providers.

(12) The Iowa psychological association.

(13) The Iowa psychiatric society.

(14) The Iowa chapter of the national association of social workers.

(15) The coalition for family and children's services in Iowa.

(16) The Iowa hospital association.

(17) The Iowa association of rural health clinics.

(18) The Iowa/Nebraska primary care association.

(19) Free clinics of Iowa.

(20) The opticians' association of Iowa, inc.

(21) The Iowa association of hearing health professionals.

(22) The Iowa speech and hearing association.

(23) The Iowa health care association.

(24) The Iowa association of area agencies on aging.

(25) AARP.

(26) The Iowa caregivers association.

(27) The Iowa coalition of home and community-based services for seniors.

(28) The Iowa adult day services association.

(29) The Iowa association of homes and services for the aging.

(30) The Iowa association for home care.

(31) The Iowa council of health care centers.

(32) The Iowa physician assistant society.

(33) The Iowa association of nurse practitioners.

(34) The Iowa nurse practitioner society.

(35) The Iowa occupational therapy association.

(36) The ARC of Iowa, formerly known as the association for retarded citizens of Iowa.

(37) The alliance for the mentally ill of Iowa.

(38) The Iowa state association of counties.

(39) The governor's developmental disabilities council.

(40) The Iowa chiropractic society.

b. Public representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, equal in number to the number of representatives of the professional and business entities specifically represented under paragraph *"a"*, appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented under paragraph *"a"*, and a majority of whom shall be current or former recipients of medical assistance or members of the families of current or former recipients.

c. The director of public health, or the director's designee.

d. The director of the department of elder affairs, or the director's designee.

e. The dean of Des Moines university osteopathic medical center, or the dean's designee.

f. The dean of the university of Iowa college of medicine, or the dean's designee.

g. The following members of the general assembly, each for a term of two years:

(1) Two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader of the house of representatives from their respective parties.

(2) One member of the senate from each of the two major political parties, appointed by the president of the senate, after consultation with the majority leader and the minority leader of the senate.

3. *a.* An executive committee of the council is created and shall consist of the following members of the council:

(1) Five of the professional or business entity members designated pursuant to subsection 2, paragraph *"a"*, and selected by the members specified under that paragraph.

(2) Five of the public members appointed pursuant to subsection 2, paragraph *"b"*, and selected by the members specified under that paragraph. Of the five public members, at least one member shall be a recipient of medical assistance.

(3) The director of public health, or the director's designee.

b. The executive committee shall meet on a monthly basis. The director of public health shall serve as chairperson of the executive committee.

c. Based upon the deliberations of the council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program.

4. For each council meeting, other than those held during the time the general assembly is in session, each legislative member of the council shall be reimbursed for actual travel and other necessary expenses and shall receive a per diem as specified in section 7E.6 for each day in attendance, as shall the members of the council or the executive committee who are recipients or the family members of recipients of medical assistance, regardless of whether the general assembly is in session.

5. The department shall provide staff support and independent technical assistance to the council and the executive committee.

6. The director shall consider the recommendations offered by the council and the executive committee in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to section 217.3 and in implementation of medical assistance program policies.

2005 Acts, ch 120, §3

249A.5 Recovery of payment.

1. Medical assistance paid to, or on behalf of, a recipient or paid to a provider of services is not recoverable,

except as provided in subsection 2, unless the assistance was incorrectly paid. Assistance incorrectly paid is recoverable from the provider, or from the recipient, while living, as a debt due the state and, upon the recipient's death, as a claim classified with taxes having preference under the laws of this state.

2. The provision of medical assistance to an individual who is fifty-five years of age or older, or who is a resident of a nursing facility, intermediate care facility for persons with mental retardation, or mental health institute, who cannot reasonably be expected to be discharged and return to the individual's home, creates a debt due the department from the individual's estate for all medical assistance provided on the individual's behalf, upon the individual's death.

a. The department shall waive the collection of the debt created under this subsection from the estate of a recipient of medical assistance to the extent that collection of the debt would result in either of the following:

(1) Reduction in the amount received from the recipient's estate by a surviving spouse, or by a surviving child who was under age twenty-one, blind, or permanently and totally disabled at the time of the individual's death.

(2) Otherwise work an undue hardship as determined on the basis of criteria established pursuant to 42 U.S.C. § 1396p(b)(3).

b. If the collection of all or part of a debt is waived pursuant to subsection 2, paragraph *"a"*, to the extent the medical assistance recipient's estate was received by the following persons, the amount waived shall be a debt due from one of the following, as applicable:

(1) The estate of the medical assistance recipient's surviving spouse or child who is blind or has a disability, upon the death of such spouse or child.

(2) A surviving child who was under twenty-one years of age at the time of the medical assistance recipient's death, upon the child reaching the age of twenty-one or from the estate of the child if the child dies prior to reaching the age of twenty-one.

(3) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient, or from the hardship waiver recipient when the hardship no longer exists.

c. For purposes of this section, the estate of a medical assistance recipient, surviving spouse, or surviving child includes any real property, personal property, or other asset in which the recipient, spouse, or child had any legal title or interest at the time of the recipient's, spouse's, or child's death, to the extent of such interests, including but not limited to interests in jointly held property, retained life estates, and interests in trusts.

d. For purposes of collection of a debt created by this subsection, all assets included in the estate of a medical assistance recipient, surviving spouse, or surviving child pursuant to paragraph *"c"* are subject to probate.

e. Interest shall accrue on a debt due under this subsection, at the rate provided pursuant to section 535.3, beginning six months after the death of a medical assistance recipient, surviving spouse, or surviving child.

f. (1) If a debt is due under this subsection from the estate of a recipient, the administrator of the nursing facility, intermediate care facility for persons with mental retardation, or mental health institute in which the recipient resided at the time of the recipient's death, and the personal representative of the recipient, if applicable, shall report the death to the department within ten days of the death of the recipient.

(2) If a personal representative or executor of an estate makes a distribution either in whole or in part of the property of an estate to the heirs, next of kin, distributees, legatees, or devisees without having executed the obligations pursuant to section 633.425, the personal representative or executor may be held personally liable

for the amount of medical assistance paid on behalf of the recipient, to the full value of any property belonging to the estate which may have been in the custody or control of the personal representative or executor.

(3) For the purposes of this paragraph, *"executor"* means executor as defined in section 633.3, and *"personal representative"* means a person who filed a medical assistance application on behalf of the recipient or who manages the financial affairs of the recipient.

[C62, 66, § 249A.13; C71, 73, 75, 77, 79, 81, § 249A.5]

83 Acts, ch 153, § 14; 94 Acts, ch 1120, §10; 95 Acts, ch 68, § 2; 96 Acts, ch 1107, § 1; 96 Acts, ch 1129, § 65, 113; 2002 Acts, ch 1086, §2, 21; 2003 Acts, ch 62, §3

249A.6 Lien.

1. When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a recipient, the department shall have a lien, to the extent of those payments, upon all monetary claims which the recipient may have against third parties. A lien under this section is not effective unless the department files a notice of lien with the clerk of the district court in the county where the recipient resides and with the recipient's attorney when the recipient's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the recipient, the recipient's attorney, or other representative. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final for purposes of this section. A compromise, including but not limited to a settlement, waiver or release, of a claim under this section does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee. A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a recipient or on behalf of a recipient which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the recipient's claim.

2. The department shall be given notice of monetary claims against third parties as follows:

a. Applicants for medical assistance shall notify the department of any possible claims against third parties upon submitting the application. Recipients of medical assistance shall notify the department of any possible claims when those claims arise.

b. A person who provides health care services to a person receiving assistance through the medical assistance program shall notify the department whenever the person has reason to believe that third parties may be liable for payment of the costs of those health care services.

c. An attorney representing an applicant for or recipient of assistance on a claim upon which the department has a lien under this section shall notify the department of the claim of which the attorney has actual knowledge, prior to filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge under this section shall include the notice to the attorney pursuant to subsection 1.

The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or district office location, is adequate legal notice of the claim.

3. The department's lien is valid and binding on an attorney, insurer, or other third party only upon notice by the department or unless the attorney, insurer, or third party has actual notice that the recipient is receiving medical assistance from the department and only to the extent to which the attorney, insurer, or third party has not made payment to the recipient or an assignee of the recipient prior to the notice. Payment of benefits

by an insurer or third party pursuant to the rights of the lienholder in this section discharges the attorney, insurer, or third party from liability to the recipient or the recipient's assignee to the extent of the payment to the department.

4. If a recipient of assistance through the medical assistance program incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim upon which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the recipient. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the recipient. An attorney acting on behalf of a recipient of medical assistance for the purpose of enforcing a claim upon which the department has a lien shall not collect from the recipient any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this section.

5. For purposes of this section the term *"third party"* includes an attorney, individual, institution, corporation, or public or private agency which is or may be 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 for or recipient of assistance under the medical assistance program.

6. The department may enforce its lien by a civil action against any liable third party.

[C79, 81, § 249A.6]

83 Acts, ch 120, § 1; 83 Acts, ch 153, § 15; 89 Acts, ch 111, § 1; 93 Acts, ch 180, §50; 94 Acts, ch 1023, §89

249A.7 Fraudulent practices investigations and audits.

A person who obtains assistance or payments for medical assistance under this chapter by knowingly making or causing to be made, a false statement or a misrepresentation of a material fact or by knowingly failing to disclose a material fact required of an applicant for aid under the provisions of this chapter and a person who knowingly makes or causes to be made, a false statement or a misrepresentation of a material fact or knowingly fails to disclose a material fact concerning the applicant's eligibility for aid under this chapter commits a fraudulent practice.

The department of inspections and appeals shall conduct investigations and audits as deemed necessary to ensure compliance with the medical assistance program administered under this chapter. The department of inspections and appeals shall cooperate with the department of human services on the development of procedures relating to such investigations and audits to ensure compliance with federal and state single state agency requirements.

[C62, 66, § 249A.15; C71, 73, 75, 77, 79, 81, § 249A.7]

90 Acts, ch 1204, §63; 97 Acts, ch 56, § 3

Footnotes

See § 714.8 et seq.

249A.8 Fraudulent practice.

A person who knowingly makes or causes to be made false statements or misrepresentations of material facts or knowingly fails to disclose material facts in application for payment of services or merchandise rendered

or purportedly rendered by a provider participating in the medical assistance program under this chapter commits a fraudulent practice.

91 Acts, ch 107, §12; 97 Acts, ch 56, § 4

249A.9 Direct payment to health care facility no deduction for service. Repealed by 84 Acts, ch 1297, § 7.

249A.10 Repealed by 81 Acts, ch 7, § 17.

249A.11 Payment for patient care segregated.

A state resource center or mental health institute, upon receipt of any payment made under this chapter for the care of any patient, shall segregate an amount equal to that portion of the payment which is required by law to be made from nonfederal funds except for any nonfederal funds received through the expansion population program pursuant to chapter 249J which shall be deposited in the IowaCare account created pursuant to section 249J.24. The money segregated shall be deposited in the medical assistance fund of the department of human services.

[C77, 79, 81, § 249A.11]

83 Acts, ch 96, § 157, 159; 85 Acts, ch 146, §3; 2000 Acts, ch 1112, §51; 2005 Acts, ch 167, §33, 66

249A.12 Assistance to persons with mental retardation.

1. Assistance may be furnished under this chapter to an otherwise eligible recipient who is a resident of a health care facility licensed under chapter 135C and certified as an intermediate care facility for persons with mental retardation.

2. A county shall reimburse the department on a monthly basis for that portion of the cost of assistance provided under this section to a recipient with legal settlement in the county, which is not paid from federal funds, if the recipient's placement has been approved by the appropriate review organization as medically necessary and appropriate. The department's goal for the maximum time period for submission of a claim to a county is not more than sixty days following the submission of the claim by the provider of the service to the department. The department's goal for completion and crediting of a county for cost settlement for the actual costs of a service under a home and community-based services waiver is within two hundred seventy days of the close of a fiscal year for which cost reports are due from providers. The department shall place all reimbursements from counties in the appropriation for medical assistance, and may use the reimbursed funds in the same manner and for any purpose for which the appropriation for medical assistance may be used.

3. If a county reimburses the department for medical assistance provided under this section and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in section 633C.1, the department shall reimburse the county on a proportionate basis. The department shall adopt rules to implement this subsection.

4. *a.* Effective July 1, 1995, the state shall be responsible for all of the nonfederal share of the costs of intermediate care facility for persons with mental retardation services provided under medical assistance to minors. Notwithstanding subsection 2 and contrary provisions of section 222.73, effective July 1, 1995, a county is not required to reimburse the department and shall not be billed for the nonfederal share of the costs of such services provided to minors.

b. Effective July 1, 1995, the state shall be responsible for all of the nonfederal share of medical assistance home and community-based services waivers for persons with mental retardation services provided to minors

and a county is not required to reimburse the department and shall not be billed for the nonfederal share of the costs of the services.

c. Effective February 1, 2002, the state shall be responsible for all of the nonfederal share of the costs of intermediate care facility for persons with mental retardation services provided under medical assistance attributable to the assessment fee for intermediate care facilities for individuals with mental retardation imposed pursuant to section 249A.21. Notwithstanding subsection 2, effective February 1, 2003, a county is not required to reimburse the department and shall not be billed for the nonfederal share of the costs of such services attributable to the assessment fee.

5. *a.* The mental health, mental retardation, developmental disabilities, and brain injury commission shall recommend to the department the actions necessary to assist in the transition of individuals being served in an intermediate care facility for persons with mental retardation, who are appropriate for the transition, to services funded under a medical assistance home and community-based services waiver for persons with mental retardation in a manner which maximizes the use of existing public and private facilities. The actions may include but are not limited to submitting any of the following or a combination of any of the following as a request for a revision of the medical assistance home and community-based services waiver for persons with mental retardation in effect as of June 30, 1996:

(1) Allow for the transition of intermediate care facilities for persons with mental retardation licensed under chapter 135C as of June 30, 1996, to services funded under the medical assistance home and community-based services waiver for persons with mental retardation. The request shall be for inclusion of additional persons under the waiver associated with the transition.

(2) Allow for reimbursement under the waiver for day program or other service costs.

(3) Allow for exception provisions in which an intermediate care facility for persons with mental retardation which does not meet size and other facility-related requirements under the waiver in effect on June 30, 1996, may convert to a waiver service for a set period of time such as five years. Following the set period of time, the facility would be subject to the waiver requirements applicable to services which were not operating under the exception provisions.

b. In implementing the provisions of this subsection, the mental health, mental retardation, developmental disabilities, and brain injury commission shall consult with other states. The waiver revision request or other action necessary to assist in the transition of service provision from intermediate care facilities for persons with mental retardation to alternative programs shall be implemented by the department in a manner that can appropriately meet the needs of individuals at an overall lower cost to counties, the federal government, and the state. In addition, the department shall take into consideration significant federal changes to the medical assistance program in formulating the department's actions under this subsection. The department shall consult with the mental health, mental retardation, developmental disabilities, and brain injury commission in adopting rules for oversight of facilities converted pursuant to this subsection. A transition approach described in paragraph *"a"* may be modified as necessary to obtain federal waiver approval.

6. *a.* Effective July 1, 2003, the provisions of the home and community-based services waiver for persons with mental retardation shall include adult day care, prevocational, and transportation services. Transportation shall be included as a separately payable service.

b. The department of human services shall seek federal approval to amend the home and community-based services waiver for persons with mental retardation to include day habilitation services. Inclusion of day habilitation services in the waiver shall take effect upon receipt of federal approval and no later than July 1, 2004.

c. The person's county of legal settlement shall pay for the nonfederal share of the cost of services provided

under the waiver, and the state shall pay for the nonfederal share of such costs if the person has no legal settlement or the legal settlement is unknown so that the person is deemed to be a state case.

d. The county of legal settlement shall pay for one hundred percent of the nonfederal share of the costs of care provided for adults which is reimbursed under a home and community-based services waiver that would otherwise be approved for provision in an intermediate care facility for persons with mental retardation provided under the medical assistance program.

7. When paying the necessary and legal expenses for intermediate care facility for persons with mental retardation services, the cost requirements of section 222.60 shall be considered fulfilled when payment is made in accordance with the medical assistance payment rates established by the department for intermediate care facilities for persons with mental retardation, and the state or a county of legal settlement shall not be obligated for any amount in excess of the rates.

[C77, 79, 81, § 249A.12]

83 Acts, ch 123, § 96, 209; 84 Acts, ch 1297, § 6; 94 Acts, ch 1120, §2; 94 Acts, ch 1163, §1; 95 Acts, ch 68, § 3; 96 Acts, ch 1129, § 113; 96 Acts, ch 1183, § 30, 31; 2002 Acts, ch 1146, §5, 6; 2003 Acts, ch 62, § 4, 8; 2003 Acts, ch 118, §1; 2004 Acts, ch 1086, §4547; 2004 Acts, ch 1090, §15, 16; 2005 Acts, ch 38, §55; 2005 Acts, ch 175, §109111

Footnotes

Appropriations to fund the costs under subsection 4 from the property tax relief fund; see § 426B.1(3)

Obligation to pay for costs of service rendered prior to July 1, 1997; disputed billings; see 2001 Acts, ch 155, §12, 13

249A.13 Pilot program on surgery for medicaid clients. Repealed by 87 Acts, ch 28, § 1.

249A.14 County attorney to enforce.

It is the intent of the general assembly that violations of law relating to the family investment program, medical assistance, and supplemental assistance shall be prosecuted by county attorneys. Area prosecutors of the office of the attorney general shall provide assistance in prosecution as required.

[C79, 81, § 249A.14]

85 Acts, ch 195, §27; 93 Acts, ch 97, §38

249A.15 Licensed psychologists eligible for payment.

The department shall adopt rules pursuant to chapter 17A entitling psychologists who are licensed in the state where the services are provided and have a doctorate degree in psychology, have had at least two years of clinical experience in a recognized health setting, or have met the standards of a national register of health service providers in psychology, to payment for services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations and of funds available for the medical assistance program.

[81 Acts, ch 7, § 16]

249A.16 New rates for services effective date.

Health care facilities licensed under chapter 135C receiving assistance payments for persons provided services by the health care facility shall submit the financial report to the department as provided by rule. Payment at a new rate is effective for services rendered as of the first day of the month in which the report is postmarked, or if the report is personally delivered, in which the report is received by the department.

[81 Acts, ch 83, § 1]

249A.17 Transitional medical assistance. Repealed by 97 Acts, ch 41, § 29. See § 249A.3.

249A.18 Cost-based reimbursement rural health clinics and federally qualified health centers.

Rural health clinics and federally qualified health centers shall receive cost-based reimbursement for one hundred percent of the reasonable costs for the provision of services to recipients of medical assistance.

98 Acts, ch 1069, §1; 99 Acts, ch 203, §51

249A.18A Resident assessment.

A nursing facility as defined in section 135C.1 shall complete a resident assessment prior to initial admission of a resident and periodically during the resident's stay in the facility. The assessment shall be completed for each prospective resident and current resident regardless of payor source. The nursing facility may utilize the same resident assessment tool required for certification of the facility under the medical assistance and federal Medicare programs to comply with this section.

2000 Acts, ch 1004, §12, 22

249A.19 Health care facilities penalty.

The department shall adopt rules pursuant to chapter 17A to assess and collect, with interest, a civil penalty for each day a health care facility which receives medical assistance reimbursements does not comply with the requirements of the federal Social Security Act, section 1919, as codified in 42 U.S.C. § 1396r. A civil penalty shall not exceed the amount authorized under 42 C.F.R. § 488.438 for health care facility violations. Any moneys collected by the department pursuant to this section shall be applied to the protection of the health or property of the residents of the health care facilities which are determined by the state or by the federal centers for Medicare and Medicaid services to be out of compliance. The purposes for which the collected moneys shall be applied may include payment for the costs of relocation of residents to other facilities, maintenance or operation of a health care facility pending correction of deficiencies or closure of the facility, and reimbursing residents for personal funds lost. If a health care facility is assessed a civil penalty under this section, the health care facility shall not be assessed a penalty under section 135C.36 for the same violation.

90 Acts, ch 1031, §1; 96 Acts, ch 1107, § 2; 2002 Acts, ch 1050, §24

249A.20 Noninstitutional health providers reimbursement.

Beginning November 1, 2000, the department shall use the federal Medicare resource-based relative value scale methodology to reimburse all applicable noninstitutional health providers, excluding anesthesia and dental services, that on June 30, 2000, are reimbursed on a fee-for-service basis for provision of services under the medical assistance program. The department shall apply the federal Medicare resource-based relative value scale methodology to such health providers in the same manner as the methodology is applied under the federal Medicare program and shall not utilize the resource-based relative value scale methodology

in a manner that discriminates between such health providers. The reimbursement schedule shall be adjusted annually on July 1, and shall provide for reimbursement that is not less than the reimbursement provided under the fee schedule established for Iowa under the federal Medicare program in effect on January 1 of that calendar year.

A provider reimbursed under section 249A.31 is not a noninstitutional health provider.

2000 Acts, ch 1221, §7; 2002 Acts, ch 1120, §2, 9

249A.20A Preferred drug list program.

1. The department shall establish and implement a preferred drug list program under the medical assistance program. The department shall submit a medical assistance state plan amendment to the centers for Medicare and Medicaid services of the United States department of health and human services, no later than May 1, 2003, to implement the program.

2. *a.* A medical assistance pharmaceutical and therapeutics committee shall be established within the department by July 1, 2003, for the purpose of developing and providing ongoing review of the preferred drug list.

b. (1) The members of the committee shall be appointed by the governor and shall include health care professionals who possess recognized knowledge and expertise in one or more of the following:

(a) The clinically appropriate prescribing of covered outpatient drugs.

(b) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

(c) Drug use review, evaluation, and intervention.

(d) Medical quality assurance.

(2) The membership of the committee shall be comprised of at least one third but not more than fifty-one percent licensed and actively practicing physicians and at least one third licensed and actively practicing pharmacists.

c. The members shall be appointed to terms of two years. Members may be appointed to more than one term. The department shall provide staff support to the committee. Committee members shall select a chairperson and vice chairperson annually from the committee membership.

3. The pharmaceutical and therapeutics committee shall recommend a preferred drug list to the department. The committee shall develop the preferred drug list by considering each drug's clinically meaningful therapeutic advantages in terms of safety, effectiveness, and clinical outcome. The committee shall use evidence-based research methods in selecting the drugs to be included on the preferred drug list. The committee shall periodically review all drug classes included on the preferred drug list and may amend the list to ensure that the list provides for medically appropriate drug therapies for medical assistance recipients and achieves cost savings to the medical assistance program. The department may procure a sole source contract with an outside entity or contractor to provide professional administrative support to the pharmaceutical and therapeutics committee in researching and recommending drugs to be placed on the preferred drug list.

4. With the exception of drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation, or cancer and drugs prescribed for mental illness with the exception of drugs and drug compounds that do not have a significant variation in a therapeutic profile or

side effect profile within a therapeutic class, prescribing and dispensing of prescription drugs not included on the preferred drug list shall be subject to prior authorization.

5. The department may negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the federal Social Security Act. The committee shall consider a product for inclusion on the preferred drug list if the manufacturer provides a supplemental rebate. The department may procure a sole source contract with an outside entity or contractor to conduct negotiations for supplemental rebates.

6. The department shall adopt rules to provide a procedure under which the department and the pharmaceutical and therapeutics committee may disclose information relating to the prices manufacturers or wholesalers charge for pharmaceuticals. The procedures established shall comply with 42 U.S.C. § 1396r-8 and with chapter 550.

7. The department shall publish and disseminate the preferred drug list to all medical assistance providers in this state.

8. Until such time as the pharmaceutical and therapeutics committee is operational, the department shall adopt and utilize a preferred drug list developed by a midwestern state that has received approval for its medical assistance state plan amendment from the centers for Medicare and Medicaid services of the United States department of health and human services.

9. The department may procure a sole source contract with an outside entity or contractor to participate in a pharmaceutical pooling program with midwestern or other states to provide for an enlarged pool of individuals for the purchase of pharmaceutical products and services for medical assistance recipients.

10. The department may adopt administrative rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph *"b"*, to implement this section.

11. Any savings realized under this section may be used to the extent necessary to pay the costs associated with implementation of this section prior to reversion to the medical assistance program. The department shall report the amount of any savings realized and the amount of any costs paid to the legislative fiscal committee on a quarterly basis.

2003 Acts, ch 112, §3, 14; 2003 Acts, ch 179, § 161; 2005 Acts, ch 3, §53

Cost requirements for a newly released generic drug product to be considered to be a preferred drug; method for determining the medical assistance program cost of a drug product; 2004 Acts, ch 1175, § 119

249A.20B Nursing facility quality assurance assessment. Repealed by 2005 Acts, ch 167, § 40, 41, 66.

2005 repeal of this section takes effect July 1, 2005, and applies retroactively to May 2, 2003; 2005 Acts, ch 167, §66

249A.21 Intermediate care facilities for persons with mental retardation assessment.

1. The department may assess intermediate care facilities for persons with mental retardation, as defined in section 135C.1, a fee in an amount not to exceed six percent of the total annual revenue of the facility for the preceding fiscal year.

2. The assessment shall be paid to the department in equal monthly amounts on or before the fifteenth day of each month. The department may deduct the monthly amount from medical assistance payments to a facility described in subsection 1. The amount deducted from payments shall not exceed the total amount of the

assessments due.

3. Revenue from the assessments shall be credited to the state medical assistance appropriation. This revenue may be used only for services for which federal financial participation under the medical assistance program is available to match state funds.

4. If federal financial participation to match the assessments made under subsection 1 becomes unavailable under federal law, the department shall terminate the imposing of the assessments beginning on the date that the federal statutory, regulatory, or interpretive change takes effect.

5. The department of human services may procure a sole source contract to implement the provisions of this section.

6. The department may adopt administrative rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph *"b"*, to implement this section, and any fee assessed pursuant to this section against an intermediate care facility for persons with mental retardation that is operated by the state may be made retroactive to October 1, 2003.

2002 Acts, 2nd Ex, ch 1001, §36, 46; 2004 Acts, ch 1085, §6, 7, 10, 11

249A.22 and 249A.23 Reserved.

249A.24 Iowa medical assistance drug utilization review commission created.

1. An Iowa medical assistance drug utilization review commission is created within the department. The commission membership, duties, and related provisions shall comply with 42 C.F.R. pt. 456, subpt. K.

2. In addition to any other duties prescribed, the commission shall make recommendations to the council on human services regarding strategies to reduce state expenditures for prescription drugs under the medical assistance program excluding provider reimbursement rates. The commission shall make initial recommendations to the council by October 1, 2002. Following approval of any recommendation by the council on human services, the department shall include the approved recommendation in a notice of intended action under chapter 17A and shall comply with chapter 17A in adopting any rules to implement the recommendation. The department shall seek any federal waiver necessary to implement any approved recommendation. The strategies to be considered for recommendation by the commission shall include at a minimum all of the following:

a. Development of a preferred drug formulary pursuant to 42 U.S.C. § 1396r-8.

b. Negotiation of supplemental rebates from manufacturers that are in addition to those required by Title XIX of the federal Social Security Act. For the purposes of this paragraph, *"supplemental rebates"* may include, at the department's discretion, cash rebates and other program benefits that offset a medical assistance expenditure. Pharmaceutical manufacturers agreeing to provide a supplemental rebate as provided in this paragraph shall have an opportunity to present evidence supporting inclusion of a product on any preferred drug formulary developed.

c. Disease management programs.

d. Drug product donation programs.

e. Drug utilization control programs.

f. Prescriber and beneficiary counseling and education.

g. Fraud and abuse initiatives.

h. Pharmaceutical case management.

i. Services or administrative investments with guaranteed savings to the medical assistance program.

j. Expansion of prior authorization for prescription drugs and pharmaceutical case management under the medical assistance program.

k. Any other strategy that has been approved by the United States department of health and human services regarding prescription drugs under the medical assistance program.

3. The commission shall submit an annual review, including facts and findings, of the drugs on the department's prior authorization list to the department and to the members of the general assembly's joint appropriations subcommittee on health and human services.

2002 Acts, 2nd Ex, ch 1003, §263, 266; 2005 Acts, ch 175, §112

249A.25 Enhanced mental health, mental retardation, and developmental disabilities services plan oversight committee. Repealed by 94 Acts, ch 1150, §4.

249A.26 State and county participation in funding for services to persons with disabilities case management.

1. The state shall pay for one hundred percent of the nonfederal share of the services paid for under any prepaid mental health services plan for medical assistance implemented by the department as authorized by law.

2. *a.* Except as provided for disallowed costs in section 249A.27, the county of legal settlement shall pay for fifty percent of the nonfederal share of the cost and the state shall have responsibility for the remaining fifty percent of the nonfederal share of the cost of case management provided to adults, day treatment, and partial hospitalization provided under the medical assistance program for persons with mental retardation, a developmental disability, or chronic mental illness. For purposes of this section, persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill. To the maximum extent allowed under federal law and regulations, the department shall consult with and inform a county of legal settlement's central point of coordination process, as defined in section 331.440, regarding the necessity for and the provision of any service for which the county is required to provide reimbursement under this subsection.

b. The state shall pay for one hundred percent of the nonfederal share of the costs of case management provided for adults, day treatment, partial hospitalization, and the home and community-based services waiver services for persons who have no legal settlement or the legal settlement is unknown so that the persons are deemed to be state cases.

c. The case management services specified in this subsection shall be paid for by a county only if the services are provided outside of a managed care contract.

3. To the maximum extent allowed under federal law and regulations, a person with mental illness or mental retardation shall not be eligible for any service which is funded in whole or in part by a county share of the nonfederal portion of medical assistance funds unless the person is referred through the central point of coordination process, as defined in section 331.440. However, to the extent federal law allows referral of a

medical assistance recipient to a service without approval of the central point of coordination process, the county of legal settlement shall be billed for the nonfederal share of costs for any adult person for whom the county would otherwise be responsible.

4. The county of legal settlement shall pay for one hundred percent of the nonfederal share of the cost of services provided to persons with chronic mental illness implemented under the adult rehabilitation option of the state medical assistance plan. The state shall pay for one hundred percent of the nonfederal share of the cost of such services provided to such persons who have no legal settlement or the legal settlement is unknown so that the persons are deemed to be state cases.

5. The state shall pay for the entire nonfederal share of the costs for case management services provided to persons seventeen years of age or younger who are served in a home and community-based services waiver program under the medical assistance program for persons with mental retardation.

6. Funding under the medical assistance program shall be provided for case management services for eligible persons seventeen years of age or younger residing in counties with child welfare decategorization projects implemented in accordance with section 232.188, provided these projects have included these persons in the service plan and the decategorization project county is willing to provide the nonfederal share of the costs.

7. Unless a county has paid or is paying for the nonfederal share of the costs of a person's home and community-based waiver services or placement in an intermediate care facility for persons with mental retardation under the county's mental health, mental retardation, and developmental disabilities services fund, or unless a county of legal settlement would become liable for the costs of services for a person at the level of care provided in an intermediate care facility for persons with mental retardation due to the person reaching the age of majority, the state shall pay for the nonfederal share of the costs of an eligible person's services under the home and community-based services waiver for persons with brain injury.

8. If a dispute arises between different counties or between the department and a county as to the legal settlement of a person who receives medical assistance for which the nonfederal share is payable in whole or in part by a county of legal settlement, and cannot be resolved by the parties, the dispute shall be resolved as provided in section 225C.8.

9. Notwithstanding section 8.39, the department may transfer funds appropriated for the medical assistance program to a separate account established in the department's case management unit in an amount necessary to pay for expenditures required to provide case management for mental health, mental retardation, and developmental disabilities services under the medical assistance program which are jointly funded by the state and county, pending final settlement of the expenditures. Funds received by the case management unit in settlement of the expenditures shall be used to replace the transferred funds and are available for the purposes for which the funds were originally appropriated.

91 Acts, ch 158, § 7; 92 Acts, ch 1241, § 74; 93 Acts, ch 172, §43; 94 Acts, ch 1150, §3; 96 Acts, ch 1183, § 32; 2002 Acts, ch 1120, §3, 9; 2004 Acts, ch 1090, § 33, 52; 2005 Acts, ch 175, §113

Prohibition against requiring county funding for medical assistance program waiver for services to persons with brain injury; 94 Acts, ch 1170, § 57

Obligation to pay for costs of service rendered prior to July 1, 1997; disputed billings; see 2001 Acts, ch 155, §12, 13

249A.26A State and county participation in funding for rehabilitation services for persons with chronic mental illness.

The county of legal settlement shall pay for the nonfederal share of the cost of rehabilitation services

provided under the medical assistance program for persons with chronic mental illness, except that the state shall pay for the nonfederal share of such costs if the person has no legal settlement or the legal settlement is unknown so that the person is deemed to be a state case.

2003 Acts, ch 62, §5; 2005 Acts, ch 175, §114

249A.27 Indemnity for case management and disallowed costs.

1. If the department contracts with a county or consortium of counties to provide case management services funded under medical assistance, the state shall appear and defend the department's employees and agents acting in an official capacity on the department's behalf and the state shall indemnify the employees and agents for acts within the scope of their employment. The state's duties to defend and indemnify shall not apply if the conduct upon which any claim is based constitutes a willful and wanton act or omission or malfeasance in office.

2. If the department is the case management contractor, the state shall be responsible for any costs included within the unit rate for case management services which are disallowed for medical assistance reimbursement by the federal centers for Medicare and Medicaid services. The contracting county shall be credited for the county's share of any amounts overpaid due to the disallowed costs. However, if certain costs are disallowed due to requirements or preferences of a particular county in the provision of case management services, the county shall not receive credit for the amount of the costs.

91 Acts, ch 158, §8; 2002 Acts, ch 1050, §25

249A.28 Reserved.

249A.29 Home and community-based services waiver providers records checks.

1. For purposes of this section and section 249A.30 unless the context otherwise requires:

a. "Consumer" means an individual approved by the department to receive services under a waiver.

b. "Provider" means an agency certified by the department to provide services under a waiver.

c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.

2. If a person is being considered by a provider for employment involving direct responsibility for a consumer or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.

3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted.

4. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or

founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.

5. If the department determines that the person has committed a crime or has a record of founded abuse which warrants prohibition of employment, the person shall not be employed by a provider.

95 Acts, ch 93, §5; 2002 Acts, ch 1120, §4

249A.30 Home and community-based services waiver service provider reimbursement.

1. The base reimbursement rate for a provider of services under a medical assistance program home and community-based services waiver for persons with mental retardation shall be recalculated at least every three years to adjust for the changes in costs during the immediately preceding three-year period.

2. The annual inflation factor used to adjust such a provider's reimbursement rate for a fiscal year shall not exceed the percentage increase in the employment cost index for private industry compensation issued by the federal department of labor, bureau of labor statistics, for the most recently completed calendar year.

2002 Acts, ch 1120, §5; 2004 Acts, ch 1086, §48

249A.31 Cost-based reimbursement mental health and developmental disabilities providers.

All of the following shall receive cost-based reimbursement for one hundred percent of the reasonable costs for the provision of services to recipients of medical assistance:

1. Providers of individual case management services for persons with mental retardation, a developmental disability, or chronic mental illness in accordance with standards adopted by the mental health, mental retardation, developmental disabilities, and brain injury commission pursuant to section 225C.6.

2. Providers of services to persons with chronic mental illness implemented under the adult rehabilitation option of the state medical assistance plan.

2002 Acts, ch 1120, §6, 9; 2004 Acts, ch 1090, §17

249A.32 Medical assistance home and community-based services waivers consumer-directed attendant care termination of contract.

1. A case manager for a medical assistance home and community-based services waiver may terminate the contract of a person providing consumer-directed attendant care services to whom payment is being made for provision of such services under the waiver if the case manager determines that the person has breached the contract by not providing the services agreed to under the contract.

2. For the purposes of this section, *"consumer"* and *"waiver"* mean consumer and waiver as defined in section 249A.29.

2003 Acts, ch 118, §2

249A.32A Home and community-based services waivers limitations.

In administering a home and community-based services waiver, the total number of openings at any one time shall be limited to the number approved for the waiver by the secretary of the United States department of health and human services. The openings shall be available on a first-come, first-served basis.

2005 Acts, ch 175, §115

249A.32B Early and periodic screening, diagnosis, and treatment funding.

The department of human services, in consultation with the Iowa department of public health and the department of education, shall continue the program to utilize the early and periodic screening, diagnosis, and treatment program funding under the medical assistance program, to the extent possible, to implement the screening component of the early and periodic screening, diagnosis, and treatment program through the schools. The department may enter into contracts to utilize maternal and child health centers, the public health nursing program, or school nurses in implementing this section.

2005 Acts, ch 175, §116

249A.33 Pharmaceutical settlement account medical assistance program.

1. A pharmaceutical settlement account is created in the state treasury under the authority of the department of human services. Moneys received from settlements relating to provision of pharmaceuticals under the medical assistance program shall be deposited in the account.

2. Moneys in the account shall be used only as provided in appropriations from the account to the department for the purpose of technology upgrades under the medical assistance program.

3. The account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys in the account shall not be considered revenue of the state, but rather shall be funds of the account. The moneys in the account are not subject to reversion to the general fund of the state under section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes of this section. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the account shall be credited to the account.

4. The treasurer of state shall provide a quarterly report of account activities and balances to the director.

2003 Acts, ch 178, §55

249A.34 Medical assistance crisis intervention team. Repealed by 2005 Acts, ch 167, § 40, 66.

249A.35 Reserved.

For future text of this section effective upon federal approval of all medical assistance state plan amendments and waivers necessary to implement chapter 514H, as enacted in 2005 Acts, ch 166, see 2005 Acts, ch 166, §1, 13