

CHAPTER 249A
MEDICAL ASSISTANCE

Referred to in §8A.512, 35D.7, 35D.10, 35D.18, 48A.19, 85.38, 135.22B, 135.61, 135C.1, 135C.4, 135C.6, 135C.20B, 135C.31, 135C.40, 135H.6, 144.13A, 147.136, 155A.32, 217.36, 222.86, 222.92, 225C.6B, 225C.35, 225D.1, 226.9B, 226.45, 231C.5A, 249.3, 249B.1, 249F.1, 249K.2, 249N.2, 249N.3, 249N.6, 252B.20, 252B.20A, 252C.2, 252E.1, 252E.2A, 252E.11, 256B.15, 283A.2, 331.390, 331.394, 331.395, 331.397, 331.397A, 422.9, 483A.24, 505.25, 509.1, 513C.3, 514.1, 514A.3B, 514B.31, 514C.8, 514E.7, 514H.5, 514I.8, 598.22A, 602.8102(82), 633.246A, 633.336, 633.641, 633.653A, 633C.3, 633E.15, 910.1

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

MEDICAL ASSISTANCE ELIGIBILITY AND MISCELLANEOUS PROVISIONS

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. “*Department*” means the department of human services.
2. “*Director*” means the director of human services.
3. “*Discretionary medical assistance*” means mandatory medical assistance or optional medical assistance provided to medically needy 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 an intellectual disability, 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 Tit. 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), paragraphs (1) through (5), and (17), or any seven of the care and services enumerated in Tit. XIX of the federal Social Security Act, section 1905(a), paragraphs (1) through (24), as codified in 42 U.S.C. §1396d(a), paragraphs (1) through (24).

4. “*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.

5. “*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 Tit. XIX of the federal Social Security Act, section 1906, as codified in 42 U.S.C. §1396e.

6. “*Mandatory medical assistance*” means payment of all or part of the costs of the care and services required to be provided by Tit. XIX of the federal Social Security Act, section 1905(a), paragraphs (1) through (5), (17), (21), and (28), as codified in 42 U.S.C. §1396d(a), paragraphs (1) through (5), (17), (21), and (28).

7. “*Medical assistance*” or “*Medicaid*” means payment of all or part of the costs of the care and services made in accordance with Tit. XIX of the federal Social Security Act and authorized pursuant to [this chapter](#).

8. “*Medical assistance program*” or “*Medicaid program*” means the program established under this chapter to provide medical assistance.

9. “*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 Tit. XIX of the federal Social Security Act, section 1905(p)(3), as codified in 42 U.S.C. §1396d(p)(3).

10. “*Optional 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 Tit. XIX of the federal Social Security Act, section 1905(a), paragraphs (6) through (16), (18) through (20), (22) through (27), and (29), as codified in 42 U.S.C. §1396d(a), paragraphs (6) through (16), and (18) through (20), (22) through (27), and (29).

11. “*Overpayment*” means any funds that a provider receives or retains under the medical assistance program to which the person, after applicable reconciliation, is not entitled. To the extent the provider and the department disagree as to whether the provider is entitled to funds received or retained under the medical assistance program, “*overpayment*” includes such funds for which the provider’s administrative and judicial review remedies under [441 IAC ch. 7](#) and [chapter 17A](#) have been exhausted. For purposes of repayment, an overpayment may include interest in accordance with [section 249A.41](#).

12. “*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](#).

13. “*Recipient*” means a person who receives medical assistance under [this chapter](#).

14. “*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; 2010 Acts, ch 1061, §180; 2012 Acts, ch 1019, §96; 2013 Acts, ch 24, §2; 2013 Acts, ch 138, §62 – 64

Referred to in §249B.1, 249F.1, 633C.1

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. Mandatory 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 Tit. 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. (1) 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.

(2) Is a pregnant woman or infant whose family income is at or below three 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, if otherwise eligible.

m. Is a child for whom adoption assistance or foster care maintenance payments are paid under Tit. 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 Tit. 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.

u. As allowed under the federal Deficit Reduction Act of 2005, Pub. L. No. 109-171, §6062, is an individual who is less than nineteen years of age who meets the federal supplemental security income program rules for disability but whose income or resources exceed such program rules, who is a member of a family whose income is at or below three hundred percent of the most recently revised official poverty guidelines published by the United States department of health and human services for the family, and whose parent complies with the requirements relating to family coverage offered by the parent's employer. Such assistance shall be provided on a phased-in basis, based upon the age of the individual.

v. (1) Beginning January 1, 2014, in accordance with section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, as codified in 42 U.S.C. §1396a(a)(10)(A)(i)(VIII), is an individual who is nineteen years of age or older and under sixty-five years of age; is not pregnant; is not entitled to or enrolled for Medicare benefits under part A, or enrolled for Medicare benefits under part B, of Tit. XVIII of the federal Social Security Act; is not otherwise described in section 1902(a)(10)(A)(i) of the federal Social Security Act; is not exempt pursuant to section 1902(k)(3), as codified in 42 U.S.C. §1396a(k)(3), and whose income as determined under 1902(e)(14) of the federal Social Security Act, as codified in 42 U.S.C. §1396a(e)(14), does not exceed one hundred thirty-three percent of the poverty line as defined in section 2110(c)(5) of

the federal Social Security Act, as codified in 42 U.S.C. §1397jj(c)(5) for the applicable family size.

(2) Notwithstanding any provision to the contrary, individuals eligible for medical assistance under this paragraph “v” shall receive coverage for benefits pursuant to 42 U.S.C. §1396u-7(b)(1)(B); adjusted as necessary to provide the essential health benefits as required pursuant to section 1302 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148; adjusted to provide prescription drugs and dental services consistent with the medical assistance state plan benefits package for individuals otherwise eligible under this subsection; and adjusted to provide habilitation services consistent with the state medical assistance program section 1915(i) waiver.

(3) (a) For individuals whose income as determined under this paragraph “v” is at or below one hundred percent of the federal poverty level, covered benefits under subparagraph (2) shall be administered consistent with program administration under [this subsection](#).

(b) For individuals whose income as determined under this paragraph “v” is above one hundred percent but not in excess of one hundred thirty-three percent of the federal poverty level, covered benefits shall be administered through provision of premium assistance for the purchase of covered benefits through the American health benefits exchange created pursuant to the Affordable Care Act, as defined in [section 249N.2](#).

w. Beginning January 1, 2014, is an individual who meets all of the following requirements:

(1) Is under twenty-six years of age.

(2) Was in foster care under the responsibility of the state on the date of attaining eighteen years of age or such higher age to which foster care is provided.

(3) Was enrolled in the medical assistance program under [this chapter](#) while in such foster care.

2. a. Mandatory 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:

(1) (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 mandatory medical assistance or optional 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 subparagraph. For the purposes of determining the amount of an individual’s resources under this subparagraph 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.

(b) Individuals eligible for assistance under this subparagraph, 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. The payment to and acceptance by an automated case management system or the department of the premium required under this subparagraph shall not automatically confer initial or continuing program eligibility on an individual. A premium paid to and accepted by the department’s premium payment process that is subsequently determined to be untimely or to have been paid on behalf of an individual ineligible for the program shall be refunded to the remitter in accordance with rules adopted by the department. Any unpaid premium shall be a debt owed the department.

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

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

(ii) Have not attained age sixty-five.

(iii) 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. An individual is considered screened for breast and cervical cancer under this subparagraph subdivision if the individual is screened by any provider or entity, and the state grantee of the United States centers for disease control and prevention funds under Tit. XV of the federal Public Health Services Act has elected to include screening activities by that provider or entity as screening activities pursuant to Tit. XV of the federal Public Health Services Act. This screening includes breast or cervical cancer screenings or related diagnostic services provided or funded by family planning centers, community health centers, or nonprofit organizations, and the screenings or services are provided to individuals who meet the eligibility requirements established by the state grantee of the United States centers for disease control and prevention funds under Tit. XV of the federal Public Health Services Act.

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

(b) An individual who meets the criteria of this subparagraph (2) shall be presumptively eligible for medical assistance.

(3) 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 for such eligibility, but whose income is not in excess of the maximum established for eligibility for discretionary 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.

(4) 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](#).

(5) 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”, subparagraph (1).

(6) 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.

(7) Individuals who are receiving state supplementary assistance as defined by [section 249.1](#).

(8) 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.

(9) Individuals eligible for family planning services under a federally approved demonstration waiver.

(10) Individuals and families who would be eligible under [subsection 1](#) or [this subsection](#) except for excess income or resources, or a reasonable category of those individuals and families.

(11) 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.

b. Notwithstanding the provisions of [this subsection](#) establishing priorities for individuals and families to receive mandatory medical assistance, the department may determine within the priorities listed in [this subsection](#) which persons shall receive mandatory medical

assistance based on income levels established by the department, subject to the limitations provided in [subsection 4](#).

3. Optional 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 of the following groups of individuals and families:

- a. Only those individuals and families described in [subsection 1](#).
- 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 “a”, subparagraph (11), 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](#), paragraph “a”, subparagraphs (3), (5), (6), (8), and (11); and [subsection 5](#), paragraph “b”, all resources of the family, other than monthly income, shall be disregarded.

5B. In determining eligibility for adults under [subsection 1](#), paragraphs “b”, “e”, “h”, “j”, “k”, “n”, “s”, and “t”; [subsection 2](#), paragraph “a”, subparagraphs (4), (5), (8), (11), and (12); and [subsection 5](#), paragraph “b”, one motor vehicle per household 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 Tit. 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 Tit. 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 Tit. 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 Tit. 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 Tit. 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 Tit. 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. In determining the eligibility of an institutionalized individual for assistance under [this chapter](#), the department shall establish a minimum community spouse resource allowance in an amount which is the greater of twenty-four thousand dollars or the minimum required as a condition of receipt of federal funding pursuant to section 1924(f)(2)(A)(i) of the federal Social Security Act, as codified in 42 U.S.C. §1396r-5(f)(2)(A)(i)174, and as adjusted pursuant to section 1924(g) of the federal Social Security Act as codified in 42 U.S.C. §1396r-5(g).

10. Group health plan cost sharing shall be provided as required by Tit. 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), subparagraph division (a).

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. Unless a surviving spouse is precluded from making an election under the terms of a premarital agreement, the failure of a surviving spouse to take an elective share pursuant to [chapter 633, subchapter 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 1985, 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](#).

14. Once initial ongoing eligibility for medical assistance is determined for a child under the age of nineteen, the department shall provide continuous eligibility for a period of up to twelve months regardless of changes in family circumstances, until the child's next annual review of eligibility under the medical assistance program, with the exception of the following children:

- a. A newborn child of a medical assistance-eligible woman.
- b. A child whose eligibility was determined under the medically needy program.
- c. A child who is eligible under a state-only funded program.
- d. A child who is no longer an Iowa resident.
- e. A child who is incarcerated in a jail or other correctional institution.

[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, §3 – 5; 85 Acts, ch 146, §2; 89 Acts, ch 104, §2 – 4; 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, §26 – 28; 98 Acts, ch 1218, §77; 99 Acts, ch 94, §1; 99 Acts, ch 203, §50; 99 Acts, ch 208, §50; 2000 Acts, ch 1060, §1 – 3; 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; 2006 Acts, ch 1104, §1; 2006 Acts, ch 1159, §4, 8; 2007 Acts, ch 218, §41 – 43, 124, 126; 2008 Acts, ch 1014, §1; 2008 Acts, ch 1188, §2, 3, 55; 2009 Acts, ch 41, §242; 2009 Acts, ch 118, §16; 2009 Acts, ch 182, §132, 134; 2011 Acts, ch 98, §16; 2011 Acts, ch 120, §3; 2013 Acts, ch 138, §65 – 71, 77, 92, 93, 106, 177, 178, 187; 2014 Acts, ch 1092, §174; 2015 Acts, ch 30, §224; 2018 Acts, ch 1041, §127; 2019 Acts, ch 116, §1

Referred to in §8A.504, 217.34, 249N.2, 249N.5, 249N.6

Spousal support debt for medical assistance to institutionalized spouse; community spouse resource allowance; [chapter 249B](#)

Elimination of monthly budget maximum or cap for individuals eligible for medical assistance program home and community-based services elderly waiver; department of human services required to track average expended per waiver recipient and report annually to general assembly by October 1; 2020 Acts, ch 1053, §1

Department of human services required to submit a medical assistance state plan amendment to provide for applicability of the federal Breast and Cervical Cancer Prevention and Treatment Act of 2009, as referenced in subsection 2, paragraph a, subparagraph (2), to both men and women and implement upon receipt of approval; 2013 Acts, ch 138, §78; Code editor notified that approval of state plan amendment occurred on October 22, 2013, with an effective date of January 1, 2014

249A.3A Medical assistance — all income-eligible children.

The department shall provide medical assistance to individuals under nineteen years of age who meet the income eligibility requirements for the state medical assistance program and for whom federal financial participation is or becomes available for the cost of such assistance.

2009 Acts, ch 118, §13

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 Tit. 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 Tit. 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.

a. 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.

b. Advanced registered nurse practitioners licensed pursuant to [chapter 152](#) and physician assistants licensed pursuant to [chapter 148C](#) 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](#) or physician assistants pursuant to [chapter 148C](#).

8. Implement the premium assistance program options described under the federal Children’s Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, for the medical assistance program. The department may adopt rules as necessary to administer these options.

9. Adopt rules pursuant to [chapter 17A](#) in determining the method and level of reimbursement for all medical and health services to be provided under the medical assistance program, 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. a. Allow supplementation of the combination of client participation and payment made through the medical assistance program for those items and services identified in [42 C.F.R. §483.10\(c\)\(8\)\(ii\)](#), by the resident of a nursing facility or the resident’s family. Supplementation under [this subsection](#) may include supplementation for provision of a private room not otherwise covered under the medical assistance program unless either of the following applies:

- (1) The private room is therapeutically required pursuant to [42 C.F.R. §483.10\(c\)\(8\)\(ii\)](#).
- (2) No room other than the private room is available.

b. The rules adopted to administer [this subsection](#) shall require all of the following if a nursing facility provides for supplementation for provision of a private room:

- (1) The nursing facility shall inform all current and prospective residents and residents’ legal representatives of the following:

(a) If the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation. Supplementation by a resident's family shall not be treated as income of the resident for purposes of medical assistance program eligibility or client participation.

(b) The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program, but the resident or resident's family is not willing or able to pay supplementation for the private room.

(c) A description and identification of the private rooms for which supplementation is available.

(d) The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

(2) For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

(a) A description and identification of the private room for which the nursing facility is receiving supplementation.

(b) The identity of the individual making the supplemental payments.

(c) The private pay charge for the private room for which the nursing facility is receiving supplementation.

(d) The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

(3) If the nursing facility only provides one type of room or all private rooms, the nursing facility shall not be eligible to request supplementation.

(4) A nursing facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources shall not be greater than the aggregate average private room rate for the type of rooms covered under the medical assistance program for which the resident would be eligible.

(5) Supplementation pursuant to [this subsection](#) shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

(6) Supplementation shall not be applicable if the facility's occupancy rate is less than fifty percent.

(7) The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

(8) A private room for which supplementation is required shall be retained for the resident consistent with existing bed-hold policies.

c. (1) A nursing facility that utilizes the supplementation option and receives supplementation under [this subsection](#) during any calendar year shall report to the department of human services annually, by January 15, the following information for the preceding calendar year:

(a) The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.

(b) The average occupancy rate of the facility on a monthly basis.

(c) The total number of residents for which supplementation was utilized.

(d) The average private pay charge for a private room in the nursing facility.

(e) For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

(2) The department shall compile the information received and shall submit the compilation to the general assembly, annually by May 1.

11. 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. 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.

12. 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.

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 Tit. 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 and disability services commission.

[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; 2009 Acts, ch 41, §243; 2009 Acts, ch 118, §18; 2010 Acts, ch 1031, §389; 2012 Acts, ch 1034, §1; 2013 Acts, ch 138, §72; 2014 Acts, ch 1140, §87, 88; 2020 Acts, ch 1020, §8, 12; 2020 Acts, ch 1063, §94

Referred to in §249A.3

Subsection 7, paragraph b amended
Subsections 11 and 15 amended

249A.4A Garnishment. Transferred to [§249A.52](#); 2013 Acts, ch 24, §14.

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 and a public member of the council selected by the public members of the council shall serve as co-chairpersons of the council.

2. *a.* The council shall consist of the following voting members:

(1) Five professional or business entity members selected by the entities specified pursuant to [subsection 3](#), paragraph “a”.

(2) Five public members appointed pursuant to [subsection 3](#), paragraph “b”. Of the five public members, at least one member shall be a recipient of medical assistance.

b. The council shall include all of the following nonvoting members:

(1) The director of public health, or the director’s designee.

(2) The director of the department on aging, or the director’s designee.

(3) The long-term care ombudsman, or the long-term care ombudsman’s designee.

(4) The dean of Des Moines university — osteopathic medical center, or the dean’s designee.

(5) The dean of the university of Iowa college of medicine, or the dean’s designee.

(6) A member of the hawk-i board created in [section 514I.5](#), selected by the members of the hawk-i board.

(7) The following members of the general assembly, each for a term of two years as provided in [section 69.16B](#):

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

(b) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

3. The voting membership of the council shall be selected or appointed as follows:

a. The five professional or business entity members shall be selected by the entities specified under this paragraph “a”. The five professional or business entity members selected shall be the president, or the president’s representative, of the professional or business entity, or a member of the professional or business entity, designated 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 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) Leading age Iowa.
- (28) The Iowa association for home care.
- (29) The Iowa council of health care centers.
- (30) The Iowa physician assistant society.
- (31) The Iowa association of nurse practitioners.
- (32) The Iowa nurse practitioner society.
- (33) The Iowa occupational therapy association.
- (34) The ARC of Iowa, formerly known as the association for retarded citizens of Iowa.
- (35) The national alliance on mental illness.
- (36) The Iowa state association of counties.
- (37) The Iowa developmental disabilities council.
- (38) The Iowa chiropractic society.
- (39) The Iowa academy of nutrition and dietetics.
- (40) The Iowa behavioral health association.
- (41) The midwest association for medical equipment services or an affiliated Iowa organization.

b. The five public members shall be public representatives which may include members

of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, 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”.

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

5. 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 who are recipients or the family members of recipients of medical assistance, regardless of whether the general assembly is in session.

6. The department shall provide staff support and independent technical assistance to the council.

7. The director shall consider the recommendations offered by the council 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; 2008 Acts, ch 1156, §36, 58; 2009 Acts, ch 23, §55; 2011 Acts, ch 129, §93, 156; 2012 Acts, ch 1023, §32; 2012 Acts, ch 1068, §1; 2013 Acts, ch 30, §48; 2016 Acts, ch 1139, §99; 2018 Acts, ch 1165, §130; 2019 Acts, ch 85, §91](#)

Referred to in [§217.3](#)

249A.5 Recovery of payment. Transferred to [§249A.53; 2013 Acts, ch 24, §14.](#)

249A.6 Assignment — lien. Transferred to [§249A.54; 2013 Acts, ch 24, §14.](#)

249A.6A Restitution. Transferred to [§249A.55; 2013 Acts, ch 24, §14.](#)

249A.7 Fraudulent practices — investigations and audits — Medicaid fraud fund. Transferred to [§249A.50; 2013 Acts, ch 24, §14.](#)

249A.8 Fraudulent practice. Transferred to [§249A.51; 2013 Acts, ch 24, §14.](#)

249A.9 and 249A.10 Reserved.

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. 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; 2010 Acts, ch 1141, §27](#)

Referred to in [§218.78, 222.92](#)

249A.12 Assistance to persons with an intellectual disability.

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 an intellectual disability.

2. If a county reimbursed the department for medical assistance provided under [this section](#), Code 2011, 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](#).

3. *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 an intellectual disability services provided under medical assistance to minors. Notwithstanding contrary provisions of [section](#)

[222.73](#), Code 2011, 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. The state shall be responsible for all of the nonfederal share of medical assistance home and community-based services waivers for persons with an intellectual disability 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. The state shall be responsible for all of the nonfederal share of the costs of intermediate care facility for persons with an intellectual disability services provided under medical assistance attributable to the assessment for intermediate care facilities for individuals with an intellectual disability imposed pursuant to [section 249A.21](#). 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.

4. a. The mental health and disability services 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 an intellectual disability, who are appropriate for the transition, to services funded under a medical assistance home and community-based services waiver for persons with an intellectual disability 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 an intellectual disability:

(1) Allow for the transition of intermediate care facilities for persons with an intellectual disability licensed under [chapter 135C](#), to services funded under the medical assistance home and community-based services waiver for persons with an intellectual disability. 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 an intellectual disability 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 and disability services 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 an intellectual disability 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 and disability services 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.

5. a. The provisions of the home and community-based services waiver for persons with an intellectual disability 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 an intellectual disability to include day habilitation services. Inclusion of day habilitation services in the waiver shall take effect upon receipt of federal approval.

6. When paying the necessary and legal expenses for intermediate care facility for persons with an intellectual disability 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 an intellectual disability, and the state shall not be obligated for any amount in excess of the rates.

7. If services associated with the intellectual disability can be covered under a medical assistance home and community-based services waiver or other medical assistance program provision, the nonfederal share of the medical assistance program costs for such coverage shall be paid from the appropriation made for the medical assistance program.

[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, §45 – 47; 2004 Acts, ch 1090, §15, 16; 2005 Acts, ch 38, §55; 2005 Acts, ch 175, §109 – 111; 2006 Acts, ch 1066, §1; 2006 Acts, ch 1115, §15; 2007 Acts, ch 22, §56; 2010 Acts, ch 1031, §384 – 387, 389; 2012 Acts, ch 1019, §99 – 103; 2012 Acts, ch 1133, §58; 2012 Acts, ch 1138, §57; 2013 Acts, ch 30, §49, 50; 2016 Acts, ch 1139, §51

Referred to in §28M.1, 331.402

249A.13 Reserved.

249A.14 County attorney to enforce. Transferred to §249A.56; 2013 Acts, ch 24, §14.

249A.15 Licensed psychologists eligible for payment — provisional licensees.

1. The department shall adopt rules pursuant to [chapter 17A](#) entitling psychologists who are licensed pursuant to [chapter 154B](#) and 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. The rules shall also provide that an individual, who holds a provisional license to practice psychology pursuant to [section 154B.6](#), is entitled to payment under [this section](#) for services provided to recipients of medical assistance, when such services are provided under the supervision of a supervisor who meets the qualifications determined by the board of psychology by rule, and claims for payment for such services are submitted by the supervisor.

2. Entitlement to payment under [this section](#) is applicable to services provided to recipients of medical assistance under both the fee-for-service and managed care payment and delivery systems. Neither the fee-for-service nor the managed care payment and delivery system shall impose a practice or supervision restriction which is inconsistent with or more restrictive than the authority already granted by law, including the authority to provide supervision in person or remotely through electronic means as specified by rule of the board of psychology.

[81 Acts, ch 7, §16]

2015 Acts, ch 137, §107, 162, 163; 2018 Acts, ch 1165, §135, 139

249A.15A Licensed marital and family therapists, licensed master social workers, licensed mental health counselors, certified alcohol and drug counselors, licensed behavior analysts, and licensed assistant behavior analysts — temporary licensees.

1. The department shall adopt rules pursuant to [chapter 17A](#) entitling marital and family therapists who are licensed pursuant to [chapter 154D](#) to payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations. The rules shall also provide that a marital and family therapist, who holds a temporary license to practice marital and family therapy pursuant to [section 154D.7](#), is entitled to payment under [this section](#) for behavioral health services provided to recipients of medical assistance, when such services are provided under the supervision of a qualified supervisor as determined

by the board of behavioral science by rule, and claims for payment for such services are submitted by the qualified supervisor.

2. The department shall adopt rules pursuant to [chapter 17A](#) entitling master social workers who hold a master's degree approved by the board of social work, are licensed as a master social worker pursuant to [section 154C.3, subsection 1](#), paragraph “b”, and provide treatment services under the supervision of an independent social worker licensed pursuant to [section 154C.3, subsection 1](#), paragraph “c”, to payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations.

3. The department shall adopt rules pursuant to [chapter 17A](#) entitling mental health counselors who are licensed pursuant to [chapter 154D](#) to payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations. The rules shall also provide that a mental health counselor, who holds a temporary license to practice mental health counseling pursuant to [section 154D.7](#), is entitled to payment under [this section](#) for behavioral health services provided to recipients of medical assistance, when such services are provided under the supervision of a qualified supervisor as determined by the board of behavioral science by rule, and claims for payment for such services are submitted by the qualified supervisor.

4. The department shall adopt rules pursuant to [chapter 17A](#) entitling alcohol and drug counselors who are certified by the nongovernmental Iowa board of substance abuse certification to payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations.

5. The department shall adopt rules pursuant to [chapter 17A](#) entitling behavior analysts and assistant behavior analysts who are licensed pursuant to [chapter 154D](#) to payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations.

6. Entitlement to payment under [this section](#) is applicable to services provided to recipients of medical assistance under both the fee-for-service and managed care payment and delivery systems. Neither the fee-for-service nor the managed care payment and delivery system shall impose a practice or supervision restriction which is inconsistent with or more restrictive than the authority already granted by law, including the authority to provide supervision in person or remotely through electronic means as specified by rule of the applicable licensing board.

[2008 Acts, ch 1187, §123; 2011 Acts, ch 29, §1; 2018 Acts, ch 1106, §12, 14; 2018 Acts, ch 1165, §136, 139](#)

249A.15B Speech pathologists eligible for payment.

The department shall adopt rules pursuant to [chapter 17A](#) entitling speech pathologists who are licensed pursuant to [chapter 154F](#), including those certified in independent practice, to payment for speech pathology services provided to recipients of medical assistance, subject to limitations and exclusions the department finds necessary on the basis of federal laws and regulations.

[2012 Acts, ch 1092, §1](#)

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.

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. Transferred to [§249A.57](#); 2013 Acts, ch 24, §14.**249A.20 Noninstitutional health providers — reimbursement.**

1. 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.

2. A provider reimbursed under [section 249A.31](#) is not a noninstitutional health provider.
2000 Acts, ch 1221, §7; 2002 Acts, ch 1120, §2, 9; 2018 Acts, ch 1041, §127

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. *a.* The pharmaceutical and therapeutics committee shall recommend a preferred drug list to the department.

b. 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.

c. The committee shall use evidence-based research methods in selecting the drugs to be included on the preferred drug list.

d. When making recommendations or determinations regarding beneficiary access to drugs and biological products for rare diseases, as defined in the federal Orphan Drug Act of 1983, Pub. L. No. 97-414, and drugs and biological products that are genetically targeted, the committee shall request and consider information from individuals who possess scientific or medical training with respect to the drug, biological product, or rare disease.

e. 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.

f. 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 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 Tit. 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 3](#), 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; 2008 Acts, ch 1031, §108; 2010 Acts, ch 1031, §347; 2010 Acts, ch 1061, §180; 2017 Acts, ch 174, §81](#)

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

249A.21 Intermediate care facilities for persons with an intellectual disability — assessment.

1. An intermediate care facility for persons with an intellectual disability, as defined in [section 135C.1](#), shall be assessed an amount for the preceding calendar quarter, not to exceed six percent of the actual paid claims for the previous quarter.

2. The assessment shall be paid by each intermediate care facility for persons with an intellectual disability to the department on a quarterly basis. An intermediate care facility for persons with an intellectual disability shall submit the assessment amount no later than thirty days following the end of each calendar quarter.

3. The department shall collect the assessment imposed and shall credit all revenues collected 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 the department determines that an intermediate care facility for persons with an intellectual disability has underpaid or overpaid the assessment, the department shall notify the intermediate care facility for persons with an intellectual disability of the amount of the unpaid assessment or refund due. Such payment or refund shall be due or refunded within thirty days of the issuance of the notice.

5. An intermediate care facility for persons with an intellectual disability that fails to pay the assessment within the time frame specified in [this section](#) shall pay, in addition to the outstanding assessment, a penalty in the amount of one and five-tenths percent of the assessment amount owed for each month or portion of each month the payment is overdue. However, if the department determines that good cause is shown for failure to comply with payment of the assessment, the department shall waive the penalty or a portion of the penalty.

6. If an assessment has not been received by the department by the last day of the third month after the payment is due, the department shall suspend payment due the intermediate care facility for persons with an intellectual disability under the medical assistance program including payments made on behalf of the medical assistance program by a Medicaid managed care contractor.

7. The assessment imposed under [this section](#) constitutes a debt due and owing the state and may be collected by civil action, including but not limited to the filing of tax liens, and any other method provided for by law.

8. 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.

9. The department of human services may procure a sole source contract to implement the provisions of [this section](#).

10. The department may adopt administrative rules under [section 17A.4, subsection 3](#), and [section 17A.5, subsection 2](#), paragraph “b”, to implement [this section](#).

[2002 Acts, 2nd Ex, ch 1001, §36, 46; 2004 Acts, ch 1085, §6, 7, 10, 11; 2012 Acts, ch 1019, §104; 2016 Acts, ch 1139, §52](#)

Referred to in [§222.60A, 249A.12](#)

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 Tit. 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. When making recommendations or determinations regarding beneficiary access to drugs and biological products for rare diseases, as defined in the federal Orphan Drug Act of 1983, Pub. L. No. 97-414, and drugs and biological products that are genetically targeted, the commission shall request and consider information from individuals who possess scientific or medical training with respect to the drug, biological product, or rare disease.
4. 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; 2010 Acts, ch 1061, §180; 2017 Acts, ch 174, §82](#)

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 state shall pay one hundred 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 an intellectual disability, a developmental disability, or chronic mental illness. For purposes of [this section](#), persons with mental disorders resulting from Alzheimer’s disease or a substance-related disorder shall not be considered to be persons with chronic mental illness.

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.

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. The state shall pay one hundred percent of the nonfederal share of the cost of services provided to adult persons with chronic mental illness who qualify for habilitation services in accordance with the rules adopted for the services.

4. 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 an intellectual disability.

5. 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.

6. The state shall pay 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.

7. 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 and 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; 2007 Acts, ch 218, §119; 2010 Acts, ch 1031, §390; 2012 Acts, ch 1019, §105, 106; 2012 Acts, ch 1133, §59, 60; 2013 Acts, ch 30, §51; 2014 Acts, ch 1026, §53; 2018 Acts, ch 1165, §74, 75](#)

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

[Elimination of monthly budget maximum or cap for individuals eligible for medical assistance program waiver for services to persons with a brain injury; department of human services required to track average expended per waiver recipient and report annually to general assembly by October 1; 2019 Acts, ch 82, §1](#)

249A.26A State and county participation in funding for rehabilitation services for persons with chronic mental illness. Repealed by [2007 Acts, ch 218, §122](#). See [§249A.26](#).

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](#)

Referred to in [§249A.26](#)

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](#)

Referred to in [§249A.32, 335.34, 414.32](#)

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

1. The base reimbursement rate for a provider of services under a medical assistance program home and community-based services waiver for persons with an intellectual disability 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; 2010 Acts, ch 1031, §390; 2013 Acts, ch 30, §52](#)

Referred to in [§249A.29](#)

249A.30A Medical assistance — personal needs allowance.

The personal needs allowance under the medical assistance program, which may be retained by a person who is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or an intermediate care facility for persons with mental illness, as defined in [section 135C.1](#), or a person who is a resident of a psychiatric medical institution for children as defined in [section 135H.1](#), shall be fifty dollars per month. A resident who has income of less than fifty dollars per month shall receive a supplement

from the state in the amount necessary to receive a personal needs allowance of fifty dollars per month, if funding is specifically appropriated for this purpose.

[2006 Acts, ch 1113, §1](#); [2007 Acts, ch 218, §44](#); [2008 Acts, ch 1032, §41](#); [2012 Acts, ch 1019, §107](#)

249A.31 Reimbursement — targeted case management services — inpatient psychiatric services.

1. Effective July 1, 2018, targeted case management services shall be reimbursed based on a statewide fee schedule amount developed by rule of the department pursuant to [chapter 17A](#).

2. Effective July 1, 2014, providers of inpatient psychiatric services for individuals under twenty-one years of age shall be reimbursed as follows:

a. For non-state-owned providers, services shall be reimbursed according to a fee schedule without reconciliation.

b. For state-owned providers, services shall be reimbursed at one hundred percent of the actual and allowable cost of providing the service.

[2002 Acts, ch 1120, §6, 9](#); [2004 Acts, ch 1090, §17](#); [2007 Acts, ch 218, §120](#); [2009 Acts, ch 121, §2, 3](#); [2010 Acts, ch 1031, §389](#); [2012 Acts, ch 1019, §108](#); [2018 Acts, ch 1165, §132](#)

Referred to in [§249A.20](#)

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 Purchase of qualified long-term care insurance policy — computation under medical assistance program.

A computation for the purposes of determining eligibility under [this chapter](#) concerning an individual who is the beneficiary of a qualified long-term care insurance policy under [chapter 514H](#) shall include consideration of the asset disregard provided in [section 514H.5](#).

[2005 Acts, ch 166, §1, 13; 2009 Acts, ch 145, §1](#)

Referred to in [§514H.5](#)

249A.36 Medical assistance quality improvement council. Repealed by 2012 Acts, ch 1138, §111.

249A.37 Health care information sharing.

1. As a condition of doing business in the state, health insurers including self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, shall do all of the following:

a. Provide, with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan, upon the request of the state, information to determine during what period the individual or the individual's spouse or dependents may be or may have been covered by a health insurer and the nature of the coverage that is or was provided by the health insurer, including the name, address, and identifying number of the plan, in accordance with [section 505.25](#), in a manner prescribed by the department of human services or as agreed upon by the department and the entity specified in [this section](#).

b. Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the medical assistance state plan.

c. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of such health care item or service.

d. Agree not to deny any claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if all of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to such claim is commenced within six years of the date that the claim was submitted by the state.

2. The department of human services may adopt rules pursuant to [chapter 17A](#) as necessary to implement [this section](#). Rules governing the exchange of information under [this section](#) shall be consistent with all laws, regulations, and rules relating to the confidentiality

or privacy of personal information or medical records, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and regulations promulgated in accordance with that Act and published in [45 C.F.R. pts. 160 – 164](#).

[2008 Acts, ch 1187, §124](#)

249A.38 Inmates of public institutions — suspension of medical assistance.

1. Following the first thirty days of commitment, the department shall suspend, but not terminate, the eligibility of an individual who is an inmate of a public institution as defined in [42 C.F.R. §435.1010](#), who is enrolled in the medical assistance program at the time of commitment to the public institution, and who remains eligible for medical assistance as an individual except for the individual's institutional status, during the entire period of the individual's commitment to the public institution.

2. *a.* A public institution shall provide the department and the social security administration with a monthly report of the individuals who are committed to the public institution and of the individuals who are discharged from the public institution. The monthly report to the department shall include the date of commitment or the date of discharge, as applicable, of each individual committed to or discharged from the public institution during the reporting period. The monthly report shall be made through the reporting system created by the department for public, nonmedical institutions to report inmate populations. Any medical assistance expenditures, including but not limited to monthly managed care capitation payments, provided on behalf of an individual who is an inmate of a public institution but is not reported to the department in accordance with [this subsection](#), shall be the financial responsibility of the respective public institution.

b. The department shall provide a public institution with the forms necessary to be used by the individual in expediting restoration of the individual's medical assistance benefits upon discharge from the public institution.

3. The department may adopt rules pursuant to [chapter 17A](#) to implement [this section](#).

[2011 Acts, ch 98, §13, 15; 2012 Acts, ch 1038, §1; 2018 Acts, ch 1165, §127; 2019 Acts, ch 81, §1](#)

SUBCHAPTER II

MEDICAL ASSISTANCE PROGRAM INTEGRITY

249A.39 Reporting of overpayment.

1. A provider who has received an overpayment shall notify in writing, and return the overpayment to, the department, the department's agent, or the department's contractor, as appropriate. The notification shall include the reason for the return of the overpayment.

2. Notification and return of an overpayment under [this section](#) shall be provided by no later than the later of either of the following, as applicable:

a. The date which is sixty days after the date on which the overpayment was identified by the provider.

b. The date any corresponding cost report is due.

3. A violation of [this section](#) is a violation of [chapter 685](#).

[2013 Acts, ch 24, §3](#)

Referred to in [§249A.47, 249A.49](#)

249A.40 Involuntarily dissolved providers — overpayments or incorrect payments.

Medical assistance paid to a provider following involuntary administrative dissolution of the provider pursuant to [chapter 490, subchapter XIV, part B](#), shall be considered incorrectly paid for the purposes of [section 249A.53](#) and the provider shall be considered to have received an overpayment for the purposes of [this subchapter](#). For the purposes of [this section](#), the overpayment shall not accrue until after a grace period of ninety days following receipt of notice by the provider of the dissolution from the department. Notwithstanding [section 490.1422](#), or any other similar retroactive provision for reinstatement, the director

shall recoup any medical assistance paid to a provider while the provider was dissolved if the provider is not retroactively reinstated within the ninety-day grace period. The principals of the provider shall be personally liable for the incorrect payment or overpayment.

2013 Acts, ch 24, §4; 2019 Acts, ch 24, §104

249A.41 Overpayment — interest.

1. Interest may be collected upon any overpayment determined to have been made and shall accrue at the rate and in the manner specified in [this section](#).

2. Prior to the provision of a notice of overpayment to the provider, interest shall accrue at the statutory rate for prejudgment interest applicable in civil actions.

3. After the provision of a notice of overpayment to the provider and after all of the provider's administrative and judicial review remedies under [441 IAC ch. 7](#) and [chapter 17A](#) have been exhausted, interest shall accrue at the statutory rate for prejudgment interest applicable in civil actions plus five percent per annum, or the maximum legal rate, whichever is lower.

4. At the discretion of the director, interest on an overpayment may be waived in whole or in part when the department determines the imposition of interest would produce an unjust result, would unduly burden the provider, or would substantially delay the prompt and efficient resolution of an outstanding audit or investigation.

2013 Acts, ch 24, §5

Referred to in [§249A.2](#)

Interest on judgments, see [§535.3](#) and [668.13](#)

249A.42 Overpayment — limitations periods.

1. An administrative action to recover an overpayment to a provider shall be commenced within five years of the date the overpayment was incurred. For the purposes of [this subsection](#), “incurred” means the date the medical assistance claim was paid, or the date any applicable reconciliation was completed, whichever is later.

2. An administrative action to impose a sanction related to an overpayment to a provider shall be commenced within five years of the date the conduct underlying the sanction concluded, or the director discovered such conduct, whichever is later.

2013 Acts, ch 24, §6

249A.43 Provider overpayment — notice — judgment.

1. Any overpayment to a provider under [this chapter](#) shall become a judgment against the provider, by operation of law, ninety days after a notice of overpayment is personally served upon the enrolled provider as required in the Iowa rules of civil procedure or by certified mail, return receipt requested, by the director or the attorney general or, if applicable, upon exhaustion of the provider's administrative and judicial review remedies under [441 IAC ch. 7](#) or [chapter 17A](#), whichever is later. The judgment is entitled to full faith and credit in all states.

2. The notice of overpayment shall include the amount and cause of the overpayment, the provider's appeal rights, and a disclaimer that a judgment may be established if an appeal is not timely filed or if an appeal is filed and at the conclusion of the administrative process under [chapter 17A](#) a determination is made that there is an overpayment.

3. An affidavit of service of a notice of entry of judgment shall be made by first class mail at the address where the debtor was served with the notice of overpayment. Service is completed upon mailing as specified in this subsection.

4. On or after the date an unpaid overpayment becomes a judgment by operation of law, the director or the attorney general may file all of the following with the district court:

a. A statement identifying, or a copy of, the notice of overpayment.

b. Proof of service of the notice of overpayment.

c. An affidavit of default, stating the full name, occupation, place of residence, and last known post office address of the debtor; the name and post office address of the department; the date or dates the overpayment was incurred; the program under which the debtor was overpaid; and the total amount of the judgment.

5. Nothing in [this section](#) shall be construed to impede or restrict alternative methods of

recovery of the overpayments specified in [this section](#) or of overpayments which do not meet the requirements of [this section](#).

[2013 Acts, ch 24, §7](#); [2013 Acts, ch 140, §59](#)

249A.44 Overpayment — emergency relief.

1. Concurrently with a withholding of payment, the imposition of a sanction, or the institution of a criminal, civil, or administrative proceeding against a provider or other person for overpayment, the director or the attorney general may bring an action for a temporary restraining order or injunctive relief to prevent a provider or other person from whom recovery may be sought, from transferring property or otherwise taking action to protect the provider's or other person's business inconsistent with the recovery sought.

2. To obtain such relief, the director or the attorney general shall demonstrate all necessary requirements for the relief to be granted.

3. If an injunction is granted, the court may appoint a receiver to protect the property and business of the provider or other person from whom recovery may be sought. The court shall assess the costs of the receiver to the provider or other person.

4. The director or the attorney general may file a lis pendens on the property of the provider or other person during the pendency of a criminal, civil, or administrative proceeding.

5. When requested by the court, the director, or the attorney general, a provider or other person from whom recovery may be sought shall have an affirmative duty to fully disclose all property and liabilities to the requester.

6. An action brought under [this section](#) may be brought in the district court for Polk county or any other county in which a provider or other person from whom recovery may be sought has its principal place of business or is domiciled.

[2013 Acts, ch 24, §8](#)

249A.45 Provider's third-party submissions.

1. The department may refuse to accept a financial and statistical report, cost report, or any other submission from any third party acting under a provider's authority or direction to prepare or submit such documents or information, for good cause shown. For the purposes of [this section](#), "good cause" includes but is not limited to a pattern or practice of submitting unallowable costs on cost reports; making a false statement or certification to the director or any representative of the department; professional negligence or other demonstrated lack of knowledge of the cost reporting process; conviction under a federal or state law relating to the operation of a publicly funded program; or submission of a false claim under [chapter 685](#).

2. If the department refuses to accept a cost report from a third party for good cause under [this section](#), the third party shall be strictly liable to the provider for all fees incurred in preparation of the cost report, as well as reasonable attorney fees and costs. The department shall not take any adverse action against a provider that results from the unintentional delay in the submission of a new cost report or other submission necessitated by the department's refusal to accept a cost report or other submission under [this section](#). The department shall notify an affected provider within seven business days of any refusal to accept a cost report.

[2013 Acts, ch 24, §9](#)

249A.46 Liability of other persons — repayment of claims.

1. The department may require repayment of medical assistance paid from the person submitting an incorrect or improper claim, the person causing the claim to be submitted, or the person receiving payment for the claim.

2. Nothing in [this section](#) shall be construed to impede or restrict alternative recovery methods for claims specified in [this section](#) or claims which do not meet the requirements of [this section](#).

[2013 Acts, ch 24, §10](#)

249A.47 Improperly filed claims — other violations — imposition of monetary recovery and sanctions.

1. In addition to any other remedies or penalties prescribed by law, including but not limited to those specified pursuant to [section 249A.51](#) or [chapter 685](#), all of the following shall be applicable to violations under the medical assistance program:

a. A person who intentionally and purposefully presents or causes to be presented to the department a claim that the department determines meets any of the following criteria is subject to a civil penalty of not more than ten thousand dollars for each item or service:

(1) A claim for medical or other items or services that the provider knows was not provided as claimed, including a claim by any provider who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a billing code that the provider knows will result in a greater payment to the provider than the billing code the provider knows is applicable to the item or service actually provided.

(2) A claim for medical or other items or services the provider knows to be false or fraudulent.

(3) A claim for a physician service or an item or service incident to a physician service by a person who knows that the individual who furnished or supervised the furnishing of the service meets any of the following:

(a) Was not licensed as a physician.

(b) Was licensed as a physician, but such license had been obtained through a misrepresentation of material fact.

(c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified.

(4) A claim for medical or other items or services furnished during a period in which the provider was excluded from providing such items or services.

(5) A claim for a pattern of medical or other items or services that a provider knows were not medically necessary.

b. A provider who intentionally and purposefully presents or causes to be presented to any person a request for payment which is in violation of the terms of either of the following is subject to a civil penalty of not more than ten thousand dollars for each item or service:

(1) An agreement with the department or a requirement of a state plan under Tit. XIX or XXI of the federal Social Security Act not to charge a person for an item or service in excess of the amount permitted to be charged.

(2) An agreement to be a participating provider.

c. A provider who is not an organization, agency, or other entity, and knowing that the provider is excluded from participating in a program under Tit. XVIII, XIX, or XXI of the federal Social Security Act at the time of the exclusion, who does any of the following, is subject to a civil penalty of ten thousand dollars for each day that the prohibited relationship occurs:

(1) Retains a direct or indirect ownership or control interest in an entity that is participating in such programs, and knows of the action constituting the basis for the exclusion.

(2) Is an officer or managing employee of such an entity.

d. A provider who intentionally and purposefully offers to or transfers remuneration to any individual eligible for benefits under Tit. XIX or XXI of the federal Social Security Act and who knows such offer or remuneration is likely to influence such individual to order or receive from a particular provider any item or service for which payment may be made, in whole or in part, under Tit. XIX or XXI of the federal Social Security Act, is subject to a civil penalty of not more than ten thousand dollars for each item or service.

e. A provider who intentionally and purposefully arranges or contracts, by employment or otherwise, with an individual or entity that the provider knows is excluded from participation under Tit. XVIII, XIX, or XXI of the federal Social Security Act, for the provision of items or services for which payment may be made under such titles, is subject to a civil penalty of not more than ten thousand dollars for each item or service.

f. A provider who intentionally and purposefully offers, pays, solicits, or receives payment,

directly or indirectly, to reduce or limit services provided to any individual eligible for benefits under Tit. XVIII, XIX, or XXI of the federal Social Security Act, is subject to a civil penalty of not more than fifty thousand dollars for each act.

g. A provider who intentionally and purposefully makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under Tit. XIX or XXI of the federal Social Security Act, is subject to a civil penalty of not more than fifty thousand dollars for each false record or statement.

h. A provider who intentionally and purposefully and without good cause fails to grant timely access, upon reasonable request, to the department for the purpose of audits, investigations, evaluations, or other functions of the department, is subject to a civil penalty of fifteen thousand dollars for each day of the failure.

i. A provider who intentionally and purposefully makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under Tit. XVIII, XIX, or XXI of the federal Social Security Act, including a managed care organization or entity that applies to participate as a provider of services or supplier in such a managed care organization or plan, is subject to a civil penalty of fifty thousand dollars for each false statement, omission, or misrepresentation of a material fact.

j. A provider who intentionally and purposefully fails to report and return an overpayment in accordance with [section 249A.39](#) is subject to a civil penalty of ten thousand dollars for each failure to report and return an overpayment.

2. In addition to the civil penalties prescribed under [subsection 1](#), for any violation specified in [subsection 1](#), a provider shall be subject to the following, as applicable:

a. For violations specified in [subsection 1](#), paragraph “a”, “b”, “c”, “d”, “e”, “g”, “h”, or “j”, an assessment of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the department because of such claim.

b. For a violation specified in [subsection 1](#), paragraph “f”, damages of not more than three times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose.

c. For a violation specified in [subsection 1](#), paragraph “i”, an assessment of not more than three times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement, omission, or misrepresentation of a material fact.

3. In determining the amount or scope of any penalty or assessment imposed pursuant to a violation specified in [subsection 1](#), the director shall consider all of the following:

a. The nature of the claims and the circumstances under which they were presented.

b. The degree of culpability, history of prior offenses, and financial condition of the person against whom the penalties or assessments are levied.

c. Such other matters as justice may require.

4. Of any amount recovered arising out of a claim under Tit. XIX or XXI of the federal Social Security Act, the department shall receive the amount bearing the same proportion paid by the department for such claims, including any federal share that must be returned to the centers for Medicare and Medicaid services of the United States department of health and human services. The remainder of any amount recovered shall be deposited in the general fund of the state.

5. Civil penalties levied under [this section](#) are appealable under [441 IAC ch. 7](#), but, notwithstanding any provision to the contrary in that chapter, the appellant shall bear the burden to prove by clear and convincing evidence that the claim was not filed improperly.

6. For the purposes of [this section](#), “claim” includes but is not limited to the submission of a cost report.

[2013 Acts, ch 24, §11](#); [2014 Acts, ch 1092, §53](#); [2018 Acts, ch 1041, §64](#)

249A.48 Temporary moratoria.

1. The Iowa Medicaid enterprise shall impose a temporary moratorium on the enrollment of new providers or provider types identified by the centers for Medicare and Medicaid

services of the United States department of health and human services as posing an increased risk to the medical assistance program.

a. [This section](#) shall not be interpreted to require the Iowa Medicaid enterprise to impose a moratorium if the Iowa Medicaid enterprise determines that imposition of a temporary moratorium would adversely affect access of recipients to medical assistance services.

b. If the Iowa Medicaid enterprise makes a determination as specified in paragraph “a”, the Iowa Medicaid enterprise shall notify the centers for Medicare and Medicaid services of the United States department of health and human services in writing.

2. The Iowa Medicaid enterprise may impose a temporary moratorium on the enrollment of new providers, or impose numerical caps or other limits that the Iowa Medicaid enterprise and the centers for Medicare and Medicaid services identify as having a significant potential for fraud, waste, or abuse.

a. Before implementing the moratorium, caps, or other limits, the Iowa Medicaid enterprise shall determine that its action would not adversely impact access by recipients to medical assistance services.

b. The Iowa Medicaid enterprise shall notify, in writing, the centers for Medicare and Medicaid services, if the Iowa Medicaid enterprise seeks to impose a moratorium under [this subsection](#), including all of the details of the moratorium. The Iowa Medicaid enterprise shall receive approval from the centers for Medicare and Medicaid services prior to imposing a moratorium under [this subsection](#).

3. a. The Iowa Medicaid enterprise shall impose any moratorium for an initial period of six months.

b. If the Iowa Medicaid enterprise determines that it is necessary, the Iowa Medicaid enterprise may extend the moratorium in six-month increments. Each time a moratorium is extended, the Iowa Medicaid enterprise shall document, in writing, the necessity for extending the moratorium.

[2013 Acts, ch 24, §12](#)

249A.49 Internet site — providers found in violation of medical assistance program.

1. The director shall maintain on the department’s internet site, in a manner readily accessible by the public, all of the following:

a. A list of all providers that the department has terminated, suspended, or placed on probation.

b. A list of all providers that have failed to return an identified overpayment of medical assistance within the time frame specified in [section 249A.39](#).

c. A list of all providers found liable for a false claims law violation related to the medical assistance program under [chapter 685](#).

2. The director shall take all appropriate measures to safeguard the protected health information, social security numbers, and other information of the individuals involved, which may be redacted or omitted as provided in [rule of civil procedure 1.422](#). A provider shall not be included on the internet site until all administrative and judicial remedies relating to the violation have been exhausted.

[2013 Acts, ch 24, §13; 2014 Acts, ch 1092, §153, 197, 199](#)

249A.50 Fraudulent practices — investigations and audits — Medicaid fraud fund.

1. 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.

2. 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.

3. *a.* A Medicaid fraud fund is created in the state treasury under the authority of the department of inspections and appeals. Moneys from penalties, investigative costs recouped by the Medicaid fraud control unit, and other amounts received as a result of prosecutions involving the department of inspections and appeals investigations and audits to ensure compliance with the medical assistance program that are not credited to the program shall be credited to the fund.

b. Notwithstanding [section 8.33](#), moneys credited to the fund from any other account or fund shall not revert to the other account or fund. Moneys in the fund shall only be used as provided in appropriations from the fund and shall be used in accordance with applicable laws, regulations, and the policies of the office of inspector general of the United States department of health and human services.

c. For the purposes of [this subsection](#), “*investigative costs*” means the reasonable value of a Medicaid fraud control unit investigator’s, auditor’s or employee’s time, any moneys expended by the Medicaid fraud control unit, and the reasonable fair market value of resources used or expended by the Medicaid fraud control unit in a case resulting in a criminal conviction of a provider under [this chapter](#) or [chapter 714](#) or [715A](#).

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

[90 Acts, ch 1204, §63](#); [97 Acts, ch 56, §3](#); [2009 Acts, ch 136, §10](#); [2011 Acts, ch 52, §1](#); [2011 Acts, ch 127, §49, 89](#); [2013 Acts, ch 24, §14](#)

C2014, §249A.50

Referred to in [§910.1](#)

Fraudulent practices, see [§714.8 – 714.14](#)

249A.51 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](#)

CS91, §249A.8

[97 Acts, ch 56, §4](#); [2013 Acts, ch 24, §14](#)

C2014, §249A.51

Referred to in [§249A.47](#)

Fraudulent practices, see [§714.8 – 714.14](#)

249A.52 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](#)

C95, §249A.4A

[2013 Acts, ch 24, §14](#)

C2014, §249A.52

249A.53 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 an intellectual disability, 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 an intellectual disability, 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; 2012 Acts, ch 1019, §97, 98; 2013 Acts, ch 24, §14

C2014, §249A.53

Referred to in §97B.39, 249A.40, 523A.303, 561.19, 633.231, 633.304A, 633.356, 633.410, 633.425

249A.54 Assignment — lien.

1. *a.* As a condition of eligibility for medical assistance, a recipient who has the legal capacity to execute an assignment shall do all of the following:

- (1) Assign to the department any rights to payments of medical care from any third party.
- (2) Cooperate with the department in obtaining payments described in subparagraph (1).
- (3) Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

b. Any amount collected by the department through an assignment shall be retained by the department as reimbursement for medical assistance payments.

c. An assignment under [this subsection](#) is in addition to an assignment of medical support payments under any other law, including [section 252E.11](#).

2. 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.

3. 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.

(1) Actual knowledge under [this section](#) shall include the notice to the attorney pursuant to [subsection 2](#).

(2) 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.

4. 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.

5. 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](#).

6. 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.

7. 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](#); [2008 Acts, ch 1014, §2](#); [2009 Acts, ch 41, §244](#); [2009 Acts, ch 133, §96](#); [2013 Acts, ch 24, §14](#)

C2014, §249A.54

249A.55 Restitution.

If restitution is ordered by the court pursuant to [section 910.2](#), and the victim is a recipient of medical assistance for whom expenditures were made as a result of the offender's criminal activities, restitution may be made to the medical assistance program in accordance with [section 910.2](#).

[2010 Acts, ch 1093, §1](#)

C2011, §249A.6A

[2013 Acts, ch 24, §14](#)

C2014, §249A.55

249A.56 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](#); [2013 Acts, ch 24, §14](#)

C2014, §249A.56

Referred to in [§331.756\(43\)](#)

249A.57 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](#)

C91, §249A.19

[96 Acts, ch 1107, §2](#); [2002 Acts, ch 1050, §24](#); [2013 Acts, ch 24, §14](#)

C2014, §249A.57