CHAPTER 177
IN-HOME HEALTH-RELATED CARE

[Prior to 7/1/83, Social Services[770] Ch 148]
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441—177.1(249) In-home health-related care. In-home health-related care is a program designed to provide nursing care in an individual's own home, as defined in rule 441—177.2(249), to an individual whose physical, developmental, or mental health prevents independent self-care.
[**ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.2(249) Definitions.

"Client participation" has the meaning assigned to it in rule 441—177.10(249).

"Nursing care" includes skilled services and personal care services.

"Own home" means an individual's house, apartment, or other living arrangement intended for single or family residential use.

"Personal care services" includes:

1. Services that assist a client with the activities of daily living, such as, but not limited to, helping the client with bathing, toileting, getting in and out of bed, ambulation, hair care, oral hygiene and administering medications that are physician-ordered but ordinarily self-administered.
2. Services that help or retrain the client in necessary skills for daily living.
3. Incidental household services that are essential to the client's health care at home and are necessary to prevent or postpone institutionalization.

"Skilled nursing services" are services for which an individualized assessment of a patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary.

"Skilled services" include skilled nursing services or other services that, based on a physician's certification, are required to be performed under the supervision of a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

"Supervising practitioner" means a physician, nurse practitioner, clinical nurse specialist, or physician assistant qualified to supervise skilled services.
[**ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.3(249) Service criteria.

177.3(1) *Skilled services.* Skilled services must be certified by a physician as provided in rule 441—177.6(249) and must be supervised by a supervising practitioner.

177.3(2) *Personal care services.* Personal care services must be certified by a physician as provided in rule 441—177.6(249). Personal care services do not require supervision by a supervising practitioner.
[**ARC 6720C**, IAB 11/30/22, effective 2/1/23; Editorial change: IAC Supplement 2/22/23]

441—177.4(249) Eligibility and application.

177.4(1) *Eligibility.* To be eligible for in-home health-related care:

a. The individual must be eligible for supplemental security income in every respect except for income.

b. A physician must certify in accordance with rule 441—177.6(249) that the individual requires either skilled services or personal care services and that those services can be provided in the individual's own home. The certification shall be provided using Form 470-0673.

c. The individual shall live in the individual's own home. Notwithstanding the foregoing, an individual will remain eligible for a period not to exceed 15 days in any calendar month when the client is temporarily absent from the client's home.

d. The individual shall obtain a physical examination report annually and shall be under the supervision of a physician.

e. The required skilled services or personal care services must not be available under any other state or federal program.

f. The countable income of the individual and spouse living in the home shall be limited to $480.55 per month if one needs care or $961.10 if both need care, after the following disregards from gross income:

(1) The amount of the basic supplemental security income standard for an individual or a couple, as applicable.

(2) When income is earned, $65.00 plus one-half of any remaining income.

(3) The amount of the supplemental security income standard for a dependent plus any established unmet medical needs, for each dependent living in the home. Any income of the dependent shall be applied to the dependent's needs before making this disregard.

(4) The amount of the established medical needs of the ineligible spouse which are not otherwise met.

(5) The amount of the established medical needs of the applicant or recipient which are not otherwise met and would not be met if the individual were eligible for the medical assistance program.

g. Income for children.

(1) All income received by the parents in the home shall be deemed to the child with the following disregards:

1. The amount of the basic supplemental security income standard for an individual when there is one parent in the home or for a couple when there are two parents in the home.

2. The amount of the basic supplemental security income standard for a dependent for each ineligible child in the home.

3. The amount of the unmet medical needs of the parents and ineligible dependents.

4. When all income is earned, an additional basic supplemental security income standard for an individual in a one-parent home or for a couple in a two-parent home.

5. When the income is both earned and unearned, $65.00 plus one-half of the remainder of the earned income.

(2) The countable income of the child shall be limited to $480.55 per month after the following disregards from gross income:

1. The amount of the basic supplemental security income standard for an individual.

2. The amount of the established medical needs of the child which are not otherwise met and would not be met if the child were eligible for the medical assistance program.

3. One-third of the child support payments received from an absent parent.

177.4(2) *Application.* Application for in-home health-related care shall be made on Form 470-5170 or 470-5170(S) and submitted to the department. An eligibility determination shall be completed within 30 days from the date of the application, unless one or more of the following conditions exist:

a. An application has been filed and is pending for federal supplemental security income benefits.

b. The application is pending because the department has not received information, which is beyond the control of the client or the department.

c. The application is pending due to the disability determination process performed through the department.

d. The application is pending because the provider agreement has not been completed and completion is beyond control of the client. When the provider agreement cannot be completed due to the client's failure to locate a provider, applications shall not be held pending beyond 60 days from the date of application.

[**ARC 7549B**, IAB 2/11/09, effective 4/1/09; **ARC 5019C**, IAB 4/8/20, effective 5/13/20; **ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.5(249) Qualifications of providers of health care services.

177.5(1) *Age.* The provider shall be at least 18 years of age.

177.5(2) *Health assessment.* The provider shall obtain certification on Form 470-0672 that the provider is physically and emotionally capable of providing assistance to another person whose physical, developmental or mental health prevents independent self-care.

a. The certification shall be based on an examination performed by:

(1) A physician; or

(2) An advanced registered nurse practitioner or physician assistant if the nurse practitioner or physician assistant is working under the direction of a physician.

b. If the provider works for an agency, the practitioner performing the examination may not be employed by the same agency.

c. The practitioner conducting the examination shall sign the certification.

d. The certification shall be submitted to the department service worker:

(1) Before the provider agreement is signed, and

(2) Annually thereafter.

177.5(3) *Qualifications.* The provider shall be qualified by training and experience to carry out the health care plan as specified in subrule 177.7(1).

177.5(4) *Relative.* The provider may be related to the client, so long as the provider is not a member of the family as defined in rule 441—130.1(234).

[**ARC 8912B**, IAB 6/30/10, effective 9/1/10; **ARC 5019C**, IAB 4/8/20, effective 5/13/20; **ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.6(249) Physician's certification.

177.6(1) *Certification requirements.* A physician must certify on Form 470-0673:

a. That the skilled services or personal care services are required by the person's physical, developmental or mental health;

b. The specific skilled services or personal care services required, the method of providing those services, and the expected duration of services; and

c. That the required skilled services and personal care services can be delivered in the individual's own home.

177.6(2) *Certification review.* After certification and any subsequent recertification, a physician must review the certification and withdraw, renew, or amend the existing certification:

a. No later than the 180th day after the existing certification;

b. More frequently than the 180th day after the existing certification if required by the physician, the service worker, or a supervising practitioner; or

c. Upon notification of initiation of Medicaid waiver services.

[**ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.7(249A) Service worker duties.

177.7(1) *Service plan.*

a. In consultation with the client's case manager and any supervising health practitioner, the service worker shall create a complete service plan for the client. The plan must avoid duplication of services and include all of the following:

(1) All of the services certified by a physician under rule 441—177.6(249).

(2) Payer sources. In-home health-related care shall be provided only when other programs cannot meet the client's need.

(3) Level of service needs.

(4) Service history. If the client is being transferred from a medical hospital or long-term care facility, the service worker shall also obtain a transfer document describing the client's current care plan.

b. In consultation with the client's case manager and any supervising health practitioner, the service worker shall review and update the service plan on or before the ninetieth day following the creation of or previous review of the service plan. The updated service plan must comply with paragraph 177.7(1)*"a."*

177.7(2) *Change in condition.* If the service worker becomes aware of any changes in the individual's condition, including discharge from a facility, that could require a change in the services provided, the service worker shall ensure that a physician reviews the existing certification and that the existing certification is either withdrawn, renewed, or amended.

177.7(3) *Service documentation.*

a. A service worker shall review the service documentation submitted by the client or provider, including any requests for supplementation of services.

b. If there are concerns as a result of such a review, there will be a change in the service plan.

[**ARC 6720C**, IAB 11/30/22, effective 2/1/23; Editorial change: IAC Supplement 2/22/23]

441—177.8(249) Supervising practitioner duties.

177.8(1) *Instruction.* The supervising practitioner shall provide instruction specific to each patient and the services each patient is receiving, including but not limited to instruction on documentation the worker should be creating and instruction on warning signs of which the worker should be aware.

177.8(2) *Schedule for reviewing documentation.* The supervising practitioner shall set up a schedule for reviewing documentation that is specific to the services being provided to that particular patient and shall review the documentation according to the schedule.

177.8(3) *Medical records.*

a. The supervising practitioner shall keep appropriate medical records, a copy of the service plan, and the physician's certification in the supervising practitioner's case file. In addition, the medical records shall include, whenever appropriate, transfer forms, physician's orders, progress notes, drug administration records, treatment records, and incident reports.

b. The supervising practitioner shall make all medical records available to the service worker, the client, and the client's legal representative.

c. The supervising practitioner shall ensure that, upon termination of the in-home care plan, the medical records are transferred to the county office of the department of human services or the office of the public health nurse.

d. The department of human services or the office of the public health nurse shall retain medical records transferred to it under paragraph 177.8(3)*"c"* for five years or, if an audit is commenced within the five years, until completion of that audit. During the period of retention, the department of human services or the office of the public health nurse shall make the medical records available to the service worker.

[**ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.9(249) Written agreements.

177.9(1) *Independent contractor.* The provider shall be an independent contractor and shall not be an agent, employee or servant of the state of Iowa, the Iowa department of human services, or any of its employees or clients.

177.9(2) *Liability coverage.* All professional health care providers shall have adequate liability coverage consistent with their responsibilities, since the department of human services assumes no responsibility for, or liability for, individuals providing care.

177.9(3) *Provider agreement.*

a. The client and the provider shall enter into an agreement using Form 470-0636 prior to the provision of service. Any reduction to the state supplemental assistance program shall be applied to the maximum amount paid by the department of human services as stated in the provider agreement by using the separate amendment to provider agreement form.

b. Written instructions for dealing with emergency situations shall be completed by the service worker and included in the provider agreement, which shall be maintained in the client's home and in the county department of human services office. The instructions shall include:

(1) The name and telephone number of the client's physician, the nurse, responsible family members or other significant persons, and the service worker;

(2) Information as to which hospital to utilize; and

(3) Information as to which ambulance service or other emergency transportation to utilize.

[**ARC 5019C**, IAB 4/8/20, effective 5/13/20; **ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.10(249) Payment.

177.10(1) *Payment approved.* Notwithstanding 42 U.S.C. 1382(c)(7), after the service manager or designee approves the service plan, payment is effective as of the later of (1) the date of the application, or (2) the date all eligibility requirements are met and qualified health care services are provided.

177.10(2) *Client participation.*

a. Except as provided in paragraph 177.10(2)*"b,"* all income remaining after excluding the amounts identified in paragraphs 177.4(1)*"f"* and *"g"* will be considered income available for services ("client

participation") and the in-home health-related care (IHHRC) program shall pay only the cost of eligible services that exceeds client participation up to the maximum benefit payable.

b. When the first month of service is less than a full month, there is no client participation for that month. Payment will be made for the actual days of service provided according to the agreed-upon rate up to the maximum benefit payable.

177.10(3) *Maximum benefit payable.* The maximum benefit payable for in-home health-related care services inclusive of all services for all providers is the reasonable charges for such services up to and including $480.55. The provider shall accept the maximum benefit payable and shall not charge the client or others in excess of that benefit.

177.10(4) *Payment.* The client or the person legally designated to handle the client's finances shall be the sole payee for payments made under the program and shall be responsible for making payment to the provider except when the client payee becomes incapacitated or dies while receiving service.

a. The department shall have the authority to issue one payment to a provider on behalf of a client payee who becomes incapacitated or dies while receiving service.

b. When continuation of an incapacitated client payee in the program is appropriate, the department shall assist the client and the client's family to legally designate a person to handle the client's finances. Guardians, conservators, protective or representative payees, or persons holding power of attorney are considered to be legally designated.

c. Temporary absence from home. Payment will not be authorized for over 15 days for any continuous absence whether or not the absence extends into a succeeding month or months.

177.10(5) *Reasonable charges.* Payment will be made only for reasonable charges for in-home health care services as determined by the service worker, who will determine reasonableness by:

a. The prevailing community standards for cost of care for similar services.

b. The availability of services at no cost to the IHHRC program.

[**ARC 6720C**, IAB 11/30/22, effective 2/1/23]

441—177.11(249) Termination. Termination of in-home health-related care shall occur under the following conditions:

177.11(1) *Request.* Upon the request of the client or legal representative.

177.11(2) *Care unnecessary.* When the client becomes sufficiently able to remain in the client's own home with services that can be provided by other sources as determined by the service worker.

177.11(3) *Additional care necessary.* When the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker in consultation with the certifying physician.

177.11(4) *Excessive costs.* When the cost of care exceeds the maximum established in subrule 177.10(3).

177.11(5) *Other services utilized.* When the service worker determines that other services can be utilized to better meet the client's needs.

177.11(6) *Terms of provider agreement not met.* When it has been determined by the service worker that the terms of the provider agreement have not been met by the client or the provider, the state supplementary assistance payment may be terminated.

177.11(7) *Failing to comply with program requirements.* When the recipient is not following the program requirements or cooperating with the program objectives including, but not limited to, a failure to provide information to program representatives.

[**ARC 7549B**, IAB 2/11/09, effective 4/1/09; **ARC 5019C**, IAB 4/8/20, effective 5/13/20; **ARC 6720C**, IAB 11/30/22, effective 2/1/23]

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