441—52.1(249) Assistance standards. Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted. Current assistance standards shall be published on the department's website. Assistance standards shall be adjusted annually to reflect cost-of-living adjustments (COLA) adopted by the Social Security Administration, in accordance with 20 CFR §§416.2095 and 416.2096. Adjustments to the assistance standards based on COLA are effective January 1 of each year.

52.1(1) *Protective living arrangement.* Assistance standards shall be established by the department as provided in rule 441—52.1(249) for care and personal allowances for persons living in a family-life home certified under rules in 441—Chapter 111.

52.1(2) *Dependent relative.* Assistance standards for the following categories shall be established by the department as provided in rule 441—52.1(249) for state supplementary assistance for dependent relatives residing in a recipient's home.

a. Aged or disabled client and a dependent relative.

b. Aged or disabled client, eligible spouse, and a dependent relative.

c. Blind client and a dependent relative.

d. Blind client, aged or disabled spouse, and a dependent relative.

e. Blind client, blind spouse, and a dependent relative.

52.1(3) *Residential care.* For periods of eligibility before July 1, 2017, the department will reimburse a recipient in either a privately operated or non-privately operated residential care facility on a flat per diem rate or on a cost-related reimbursement system with a maximum per diem rate, established consistent with the assistance standards principles provided in rule 441—52.1(249). The department shall establish a cost-related per diem rate for each licensed residential care facility choosing the cost-related reimbursement method of payment according to rule 441—54.3(249).

For periods of eligibility beginning July 1, 2017, and thereafter, payment to a recipient in a privately operated licensed residential care facility shall be based on the maximum per diem rate. Reimbursement for recipients in non-privately operated residential care facilities will be based on the flat per diem rate or be based on the cost-related reimbursement system with a maximum per diem rate, established consistent with the assistance standards principles provided in rule 441—52.1(249).

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule shall be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care shall be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

(1) When income is earned, impairment related work expenses, as defined by SSI plus $65 plus one-half of any remaining earned income.

(2) An allowance established by the department consistent with rule 441—52.1(249) shall be given to meet personal expenses and Medicaid copayment expenses.

(3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse's countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard shall be made.

(4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent's countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.

(5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid

copayment expenses, shall also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family-life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry shall not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

b. Payment is made for only the days the recipient is a resident of the facility. Payment shall be made for the date of entry into the facility, but not the date of death or discharge.

c. Payment shall be made in the form of a grant to the recipient on a post payment basis.

d. Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

e. Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year, unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence which exceeds the 30-day annual limit. This information shall be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, Form 470-0042, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions at rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

f. Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

g. The per diem rate established for recipients of state supplementary assistance shall not exceed the average rate established by the facility for private pay residents.

(1) Residents placed in a facility by another governmental agency are not considered private paying individuals. Payments received by the facility from such an agency shall not be included in determining the average rate for private paying residents.

(2) To compute the facilitywide average rate for private paying residents, the facility shall accumulate total monthly charges for those individuals over a six-month period and divide by the total patient days care provided to this group during the same period of time.

52.1(4) *Blind.* The standard for a blind recipient not receiving another type of state supplementary assistance is $22 per month.

52.1(5) *In-home, health-related care.* Payment to a person receiving in-home, health-related care shall be made in accordance with rules in 441—Chapter 177.

52.1(6) *Minimum income level cases.* The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions which were in effect in October 1972 shall be utilized.

52.1(7) *Supplement for Medicare and Medicaid eligibles.* Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be $1 per month.

This rule is intended to implement Iowa Code chapter 249.

[**ARC 7605B**, IAB 3/11/09, effective 4/15/09; **ARC 8440B**, IAB 1/13/10, effective 3/1/10; **ARC 9965B**, IAB 1/11/12, effective 1/1/12; **ARC 0064C**, IAB 4/4/12, effective 5/9/12; **ARC 0489C**, IAB 12/12/12, effective 1/1/13; **ARC 0633C**, IAB 3/6/13, effective 5/1/13; **ARC 1268C**, IAB 1/8/14, effective 1/1/14; **ARC 1352C**, IAB 3/5/14, effective 4/9/14; **ARC 1813C**, IAB 1/7/15, effective 1/1/15; **ARC 1892C**, IAB 3/4/15, effective 4/8/15; **ARC 2363C**, IAB 1/6/16, effective 1/1/16; **ARC 2426C**, IAB 3/2/16, effective 4/6/16; **ARC 2891C**, IAB 1/4/17, effective 1/1/17; **ARC 2958C**, IAB 3/1/17, effective 4/5/17; **ARC 3441C**, IAB 11/8/17, effective 10/11/17; **ARC 3599C**, IAB 1/31/18, effective 1/5/18; **ARC 3715C**, IAB 3/28/18, effective 5/2/18; **ARC 4220C**, IAB 1/2/19, effective 1/1/19]