

441—79.15(249A) Provider enrollment.

79.15(1) Application request. Iowa Medicaid providers, including those enrolled with an MCO, shall begin the enrollment process by completing the appropriate application on the department's website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit a Medicaid HCBS Provider Application form at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit an Iowa Medicaid Ordering/Referring Provider Enrollment Application form.

c. All other providers shall submit an Iowa Medicaid Provider Enrollment Application form.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.11(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in rule 441—82.3(249A).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

g. Health insurance premium payment (HIPP) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

79.15(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to Iowa Medicaid at the department's address.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit an Assertive Community Services (ACS) Provider Agreement Addendum and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. Reserved.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C) as amended to July 1, 2026.

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under Iowa Code section 249A.48.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.15(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR §455.460 as amended to July 1, 2026.

79.15(3) Program integrity information requirements.

a. All providers, including but not limited to MCOs and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455 as amended to July 1, 2026. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

- (1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;
- (2) Has been or is subject to a payment suspension under a federally funded health care program;
- (3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;
- (4) Has had its billing privileges denied or revoked;
- (5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.15(3)“a”(1), “a”(2), “a”(3), “a”(4), or “a”(5).

b. Iowa Medicaid may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 2506, but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. Iowa Medicaid will deny enrollment to or immediately disenroll any person that Iowa Medicaid, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and will deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)“c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.15(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450 as amended to July 1, 2026.

a. For the types of providers that are recognized as a provider under the Medicare program, Iowa Medicaid will use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518 as amended to July 1, 2026.

b. Provider types not assigned a screening level by the Medicare program will be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450 as amended to July 1, 2026.

c. Adjustment of risk level. Iowa Medicaid will adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) Iowa Medicaid imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) Iowa Medicaid or CMS in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.15(5) Notification. A provider will be notified of the decision on the provider’s application within 30 calendar days of receipt by Iowa Medicaid of a complete and correct application with all required documents, including but not limited to, if applicable, any application fees or screening results.

79.15(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 2506.

79.15(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by Iowa Medicaid.

79.15(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.15(9) No payment will be made to a provider for care or services provided prior to the effective date of Iowa Medicaid’s approval of an application.

79.15(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided will be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.15(11) An amendment to an application shall be submitted to Iowa Medicaid and will be approved or denied within 30 calendar days. Approval of an amendment will be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by Iowa Medicaid. Denial of an amendment may be appealed under 441—Chapter 2506.

79.15(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.15(13) Report of changes. The provider shall inform Iowa Medicaid of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include but are not limited to changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.15(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, Iowa Medicaid may immediately terminate the provider’s Medicaid enrollment. The termination may be appealed under 441—Chapter 2506. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to Iowa Medicaid in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider’s failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 2506.

79.15(14) Provider termination or denial of enrollment. Iowa Medicaid must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416 as amended to July 1, 2026.

79.15(15) Temporary moratoria. Iowa Medicaid must impose any temporary moratorium pursuant to Iowa Code section 249A.48.

79.15(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.15(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.15(3) or any failure to report a change required by subrule 79.15(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed Iowa Medicaid while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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