CHAPTER 249A

MEDICAL ASSISTANCE

Referred to in §8A.512, 35D.7, 35D.10, 35D.18, 48A.19, 85.38, 135.22B, 135.61, 135B.1, 135C.1, 135C.2, 135C.4, 135C.6, 135C.20B, 135C.31, 135C.40, 135H.6, 135R.1, 144.13A, 147.136, 217.36, 222.86, 222.92, 225D.1, 226.9B, 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, 282.35, 283A.2, 432.1B, 483A.24, 505.25, 505.34, 509.1, 510B.1, 510D.1, 513C.3, 514.1, 514A.3B, 514B.31, 514B.32, 514C.8, 514C.36, 514E.7, 514F.8, 514F.9, 514H.5, 514I.8, 598.22A, 602.8102(82), 633.246A, 633.336, 633.641, 633.653A, 633C.3, 633E.15, 910.1

See Iowa Acts for special provisions relating to transfers and appropriations of unencumbered or unobligated moneys to the medical assistance program in a given year
See Iowa Acts for special provisions relating to medical assistance reimbursements in a given year
Brain injury services program, §135.22B
Health insurance data match program, §505.25
Reimbursement rate add-on methodology and annual inflation adjustment for services to individuals who meet nursing facility level of care requirements and are on the sex offender registry, 2023 Acts, ch 160, §1

SUBCHAPTER I

MEDICAL ASSISTANCE ELIGIBILITY AND MISCELLANEOUS PROVISIONS

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 health and human services.
2. *"Director"* means the director of health and 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; 2023 Acts, ch 19, §796

Referred to in §135D.2, 239.1, 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 twelve months 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 family income is not more than two hundred fifteen 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 whose family income while pregnant is at or below two hundred fifteen 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 for an individual and twenty-one thousand dollars of available resources for a couple 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; 2024 Acts, ch 1141, §1, 4; 2025 Acts, ch 133, §7

Referred to in §217.34, 249N.2, 249N.5, 249N.6, 421.65

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 health and human services required to track average expended per waiver recipient and report annually to general assembly by December 30; 2020 Acts, ch 1053, §1; 2022 Acts, ch 1109, §3; 2023 Acts, ch 19, §1358

Subsection 2, paragraph a, subparagraph (1), subparagraph division (a) amended

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.

2. Require providers to share information with the department as necessary to identify, prevent, or respond to child abuse as defined in section 232.68, and dependent adult abuse as defined in section 235B.2.

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 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, appeals, and licensing 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, appeals, and licensing shall issue a decision which is subject to review by the department. Judicial review of the decisions of the department may be sought in accordance with chapter 17A. If a petition for judicial review is filed, the department 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.

[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; 2023 Acts, ch 19, §797, 798, 1961; 2024 Acts, ch 1018, §10, 13, 14; 2024 Acts, ch 1161, §101, 137; 2025 Acts, ch 135, §45

Referred to in §249A.3
2024 amendment to subsection 1 applies retroactively to reports due on or after January 1, 2024; 2024 Acts, ch 1018, §14
2024 strike of subsection 15 effective July 1, 2025; 2024 Acts, ch 1161, §137
NEW subsection 2
Subsection 15 stricken

249A.4A Health care coordination and intervention teams.

1. For purposes of this section, *"health care provider"* means a health care provider as defined in section 135.24, a mental health professional, or a substance use professional.

2. The director may establish health care coordination and intervention teams as part of the state medical assistance program to conduct individual case reviews to determine whether additional health services or interventions may be appropriate for an individual's care needs.

3. *a.* A health care coordination and intervention team shall review individual cases including but not limited to cases involving individuals with complex conditions who are in need of urgent placement and services.

b. A review of an individual case by a health care coordination and intervention team may be initiated by the department or by a health care provider.

c. In conducting an individual case review, a health care coordination and intervention team shall:

(1) Review and analyze all relevant case information for the purpose of recommending additional health services, treatments, and interventions as appropriate to meet the individual's needs and to ensure the protection of human health and safety.

(2) Consult with the individual's health care providers to assist and facilitate care coordination and treatment referral actions as appropriate.

(3) Collect and review clinical records and other pertinent information, both confidential and nonconfidential, from hospitals and health care providers as necessary to review the individual's health treatment needs.

4. *a.* Upon request of a health care coordination and intervention team, a hospital or health care provider shall provide records relating to an individual case being reviewed by the health care coordination and intervention team.

b. Upon request of a health care coordination and intervention team, a person in possession or control of medical, investigative, assessment, or other information pertaining to an individual case under review by the health care coordination and intervention team shall provide the information to the health care coordination and intervention team.

c. Confidential records and information provided to a health care coordination and intervention team under this subsection shall remain confidential and the health care coordination and intervention team shall not release the records or information to any person or entity without a court order.

d. A person or entity shall not be liable for providing records or information requested

by a health care coordination and intervention team under this subsection to the health care coordination and intervention team or to the department.

5. A health care coordination and intervention team member, and an agent of a health care coordination and intervention team member, shall be immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation made provided that the team member or agent acted in good faith and without malice in carrying out official duties as a member of a health care coordination and intervention team or an agent of a health care coordination and intervention team member.

6. Subject to federal law, individual case reviews conducted pursuant to this section shall be considered care coordination as defined in section 135D.2.

2024 Acts, ch 1075, §7, 8
Referred to in §282.35

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 as necessary. The director's designee responsible for public health or their designee 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's designee responsible for public health or their designee.

(2) The long-term care ombudsman, or the long-term care ombudsman's designee.

(3) The dean of Des Moines university college of osteopathic medicine, or the dean's designee.

(4) The dean of the university of Iowa college of medicine, or the dean's designee.

(5) The following members of the general assembly, each for a term of two years as provided in section 4A.13:

(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 the medical assistance budget 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; 2023 Acts, ch 19, §799; 2024 Acts, ch 1170, §423, 472
Referred to in §217.3, 514I.2

249A.5 through 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.

[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; 2023 Acts, ch 19, §800

Referred to in §218.78, 218.97, 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 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 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.

5. 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.

6. 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; 2023 Acts, ch 19, §801; 2024 Acts, ch 1161, §102, 137
Referred to in §28M.1, 331.402
*Section 222.60 repealed by 2024 Acts, ch 1161, §135; corrective legislation is pending
2024 strike of subsection 4 effective July 1, 2025; 2024 Acts, ch 1161, §137
Subsection 4 stricken and former subsections 5 – 7 renumbered as 4 – 6

249A.13 Medicaid managed care organization premiums fund.

1. A Medicaid managed care organization premiums fund is created in the state treasury under the authority of the department of health and human services. Moneys collected by the director of the department of revenue as taxes on premiums pursuant to section 432.1B shall be deposited in the fund.

2. Moneys in the fund are appropriated to the department of health and human services for the purposes of the medical assistance program.

3. Notwithstanding section 8.33, moneys in the fund that remain unencumbered or unobligated at the close of a fiscal year shall not revert but shall remain available for expenditure for the purposes designated. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys in the fund shall be credited to the fund.

2023 Acts, ch 158, §3
Referred to in §432.1B

249A.14 Sex reassignment surgeries or associated procedures — reimbursement prohibited.

1. Moneys appropriated from the general fund of the state to the department for the medical assistance program shall not be used for reimbursement for sex reassignment surgery or associated procedures, including hormone therapy or other medical interventions intended to alter primary or secondary sex characteristics related to an individual's gender dysphoria diagnosis.

2. This section shall not be construed to prohibit Medicaid program reimbursement for services not described under subsection 1 that are otherwise covered under the Medicaid program.

3. The department of health and human services shall adopt rules pursuant to chapter 17A to administer this section.

2025 Acts, ch 169, §14
NEW section

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 behavioral health professionals 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 behavioral health professionals.

[81 Acts, ch 7, §16]

2015 Acts, ch 137, §107, 162, 163; 2018 Acts, ch 1165, §135, 139; 2024 Acts, ch 1170, §507

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 health professionals 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 behavioral health professionals, 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 health professionals 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 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; 2023 Acts, ch 19, §802; 2024 Acts, ch 1170, §508

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 Reserved.

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.

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; 2022 Acts, ch 1109, §1

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 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; 2023 Acts, ch 19, §803

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 health and human services regarding strategies to reduce state expenditures for prescription drugs under the medical assistance program excluding provider reimbursement rates. Following approval of any recommendation by the council on health and 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.

2002 Acts, 2nd Ex, ch 1003, §263, 266; 2005 Acts, ch 175, §112; 2010 Acts, ch 1061, §180; 2017 Acts, ch 174, §82; 2023 Acts, ch 19, §804; 2024 Acts, ch 1018, §11, 13, 14

2024 strike of subsection 4 applies retroactively to reports due on or after January 1, 2024; 2024 Acts, ch 1018, §14

249A.25 Reserved.

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 use 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; 2023 Acts, ch 19, §805

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 health and human services required to track average expended per waiver recipient and report annually to general assembly by December 30; 2019 Acts, ch 82, §1; 2022 Acts, ch 1109, §2; 2023 Acts, ch 19, §1358

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 Hospital directed payment — prohibition of pass-through on non-Medicaid payors.

A hospital participating in the hospital directed payment program pursuant to 42 C.F.R. §438.6 shall not knowingly pass on the directed payment increase for health care services provided to non-Medicaid payors, including as a fee or rate increase. If a hospital violates this section, the hospital shall not receive the directed payment but shall instead only be reimbursed the hospital base reimbursement rate for health care services provided under the medical assistance program for one year from the date the violation is discovered.

2023 Acts, ch 158, §9

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

4. In an evaluation, the record check evaluation system 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 record check evaluation system 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 record check evaluation system's conditions relating to the employment, which may include completion of additional training.

5. If the record check evaluation system 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; 2023 Acts, ch 19, §806
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.

1. 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-five dollars per month.

2. A resident who has income of less than fifty-five dollars per month shall receive a supplement from the state in the amount necessary to receive a personal needs allowance of fifty-five dollars per month. The general assembly shall annually appropriate a sufficient amount from the general fund of the state to the department of health and human services for this purpose.

2006 Acts, ch 1113, §1; 2007 Acts, ch 218, §44; 2008 Acts, ch 1032, §41; 2012 Acts, ch 1019, §107; 2024 Acts, ch 1157, §43; 2025 Acts, ch 169, §19
Section amended

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, in consultation with 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; 2023 Acts, ch 19, §807

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. 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; 2023 Acts, ch 19, §808

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 Duties of third parties.

1. For the purposes of this section, "*Medicaid payor*", "*recipient*", "*third party*", and "*third-party benefits*" mean the same as defined in section 249A.54.

2. The third-party obligations specified under this section are a condition of doing

business in the state. A third party that fails to comply with these obligations shall not be eligible to do business in the state.

3. A third party that is a carrier, as defined in section 514C.13, shall enter into a health insurance data match program with the department for the sole purpose of comparing the names of the carrier's insureds with the names of recipients as required by section 505.25.

4. A third party shall do all of the following:

a. Cooperate with the Medicaid payor in identifying recipients for whom third-party benefits are available including but not limited to providing information to determine the period of potential third-party coverage, the nature of the coverage, and the name, address, and identifying number of the coverage. In cooperating with the Medicaid payor, the third party shall provide information upon the request of the Medicaid payor in a manner prescribed by the Medicaid payor or as agreed upon by the department and the third party.

b. (1) Accept the Medicaid payor's rights of recovery and assignment to the Medicaid payor as a subrogee, assignee, or lienholder under section 249A.54 for payments which the Medicaid payor has made under the Medicaid state plan or under a waiver of such state plan.

(2) In the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under Tit. XIX of the federal Social Security Act, accept authorization provided by the Medicaid payor that the health care item or service is covered under the Medicaid state plan or waiver of such state plan for such individual, as if such authorization were the prior authorization made by the third party for such item or service.

c. If, on or before three years from the date a health care item or service was provided, the Medicaid payor submits an inquiry regarding a claim for payment that was submitted to the third party, respond to that inquiry not later than sixty days after receiving the inquiry.

d. Respond to any Medicaid payor's request for payment of a claim described in paragraph "*c*" not later than ninety business days after receipt of written proof of the claim, either by paying the claim or issuing a written denial to the Medicaid payor.

e. Not deny any claim submitted by a Medicaid payor solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point-of-sale that is the basis of the claim; or in the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act, solely on the basis of a failure to obtain prior authorization for the health care item or service for which the claim is submitted if all of the following conditions are met:

(1) The claim is submitted to the third party by the Medicaid payor no later than three years after the date on which the health care item or service was furnished.

(2) Any action by the Medicaid payor to enforce its rights under section 249A.54 with respect to such claim is commenced not later than six years after the Medicaid payor submits the claim for payment.

5. Notwithstanding any provision of law to the contrary, the time limitations, requirements, and allowances specified in this section shall apply to third-party obligations under this section.

6. The department may adopt rules pursuant to chapter 17A as necessary to administer 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; 2023 Acts, ch 19, §809, 810; 2023 Acts, ch 158, §1

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

Referred to in §514I.8B

249A.38A Residents of mental health institutes — retaining of Medicaid eligibility.

Notwithstanding any provision of law to the contrary, a Medicaid recipient residing at the state mental health institute at Cherokee or the state mental health institute at Independence shall retain Medicaid eligibility during the period of the Medicaid recipient's stay for which federal financial participation is available.

2024 Acts, ch 1157, §50

249A.38B Supported community living services.

1. As used in this section, *"supported community living service"* means a service provided in a noninstitutional setting to persons sixteen years of age and older with mental illness, an intellectual disability, brain injury, or developmental disabilities to meet the persons' daily living needs.

2. The department shall adopt rules pursuant to chapter 17A establishing minimum standards for supported community living services.

3. The department shall determine whether to grant, deny, or revoke approval for any supported community living service.

4. Approved supported community living services may receive funding from the state, federal and state social services block grant funds, and other appropriate funding sources, consistent with state legislation and federal regulations. The funding may be provided on a per diem, per hour, or grant basis, as appropriate.

2024 Acts, ch 1161, §103, 137

Referred to in §135C.6

Section effective July 1, 2025; 2024 Acts, ch 1161, §137

NEW section

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 administrative dissolution of the provider pursuant to chapter 490, subchapter XIV, part 2, 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; 2021 Acts, ch 165, §219, 230

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.42A Overpayment — subsequent ineligibility of recipient — recovery — recoupment — reimbursement.

Notwithstanding any provision to the contrary, if a recipient is deemed ineligible for medical assistance following delivery of care or service by a provider, in an administrative action to recover an overpayment to the provider based solely on the grounds of such recipient's ineligibility, the department acting as the state Medicaid agency shall reimburse the provider for any recoupment of an overpayment using state-only funds for care or services delivered if all of the following conditions are met:

1. The provider verified eligibility through the eligibility and verification system or the secure web portal of, and obtained any necessary prior authorization for, the recipient on whose behalf payment was made to the provider prior to the delivery of care or service to the recipient.
2. The provider documented the eligibility verification performed and any necessary prior authorization obtained pursuant to subsection 1 in a manner and format established by the department by rule, and retained the required documentation in the recipient's file.

2022 Acts, ch 1065, §1; 2022 Acts, ch 1153, §10

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 Medicaid program 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 Medicaid program.

a. This section shall not be interpreted to require the Medicaid program to impose a moratorium if the Medicaid program determines that imposition of a temporary moratorium would adversely affect access of recipients to medical assistance services.

b. If the Medicaid program makes a determination as specified in paragraph *"a"*, the Medicaid program shall notify the centers for Medicare and Medicaid services of the United States department of health and human services in writing.

2. The Medicaid program may impose a temporary moratorium on the enrollment of new providers, or impose numerical caps or other limits that the Medicaid program 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 Medicaid program shall determine that its action would not adversely impact access by recipients to Medicaid services.

b. The Medicaid program shall notify, in writing, the centers for Medicare and Medicaid services, if the Medicaid program seeks to impose a moratorium under this subsection, including all of the details of the moratorium. The Medicaid program shall receive approval

from the centers for Medicare and Medicaid services prior to imposing a moratorium under this subsection.

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

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

2013 Acts, ch 24, §12; 2023 Acts, ch 19, §811

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, appeals, and licensing shall conduct investigations and audits as deemed necessary to ensure compliance with the medical assistance program administered under this chapter. The department of inspections, appeals, and licensing shall cooperate with the department 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, appeals, and licensing. 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, appeals, and licensing 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. Any funds remaining in the Medicaid fraud fund at the close of a fiscal year are appropriated to the department of health and human services to supplement any medical assistance program appropriation for the same fiscal year to be used for medical assistance reimbursement and associated costs, including program administration and costs associated with program implementation.

d. 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

2023 Acts, ch 19, §812, 1962, 1963; 2024 Acts, ch 1157, §47

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.

3. *a.* Following the death of an individual who is a designated beneficiary of an account established under a participation agreement pursuant to chapter 12I, all of the following shall apply to the extent permitted pursuant to chapter 12I and under federal law including section 529A of the Internal Revenue Code:

(1) The department shall not seek recovery of any account balance remaining in the designated beneficiary's account for medical assistance paid to or on behalf of the designated beneficiary on or after the date the participation agreement was entered into and the account established for the designated beneficiary.

(2) The department shall not file a claim for payment under section 529A(f) of the Internal Revenue Code.

(3) Any account balance remaining in the designated beneficiary's account may be transferred to an account for another eligible individual specified by the designated beneficiary, or if another eligible beneficiary is not so designated, then the account balance

shall be transferred to the estate of the designated beneficiary or to the successor as defined in section 633.356.

b. For the purposes of this section, *"designated beneficiary"*, *"Internal Revenue Code"*, and *"participation agreement"* mean the same as defined in section 12I.1.

c. For the purposes of this section, *"eligible individual"* means the same as defined in section 529A of the Internal Revenue Code.

[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

2021 Acts, ch 136, §7

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

249A.54 Responsibility for payment on behalf of Medicaid-eligible persons — liability of other parties.

1. It is the intent of the general assembly that a Medicaid payor be the payor of last resort for medical services furnished to recipients. All other sources of payment for medical services are primary relative to medical assistance provided by the Medicaid payor. If benefits of a third party are discovered or become available after medical assistance has been provided by the Medicaid payor, it is the intent of the general assembly that the Medicaid payor be repaid in full and prior to any other person, program, or entity. The Medicaid payor shall be repaid in full from and to the extent of any third-party benefits, regardless of whether a recipient is made whole or other creditors are paid.

2. For the purposes of this section:

a. *"Collateral"* means all of the following:

(1) Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's agent, related to any covered injury or illness, or medical services that necessitated that the Medicaid payor provide medical assistance to the recipient.

(2) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(3) Proceeds.

b. *"Covered injury or illness"* means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which the Medicaid payor is, or may be, obligated to provide, or has provided, medical assistance.

c. *"Medicaid payor"* means the department or any person, entity, or organization that is legally responsible by contract, statute, or agreement to pay claims for medical assistance including but not limited to managed care organizations and other entities that contract with the state to provide medical assistance under chapter 249A.

d. *"Medical service"* means medical or medically related institutional or noninstitutional care, or a medical or medically related institutional or noninstitutional good, item, or service covered by Medicaid.

e. *"Payment"* as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. *"To pay"* means to make payment.

f. *"Proceeds"* means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds from the collateral and includes insurance payable because of loss or damage to the collateral or proceeds. *"Cash proceeds"* include money, checks, and deposit accounts and similar proceeds. All other proceeds are *"noncash proceeds"*.

g. *"Recipient"* means a person who has applied for medical assistance or who has received medical assistance.

h. *"Recipient's agent"* includes a recipient's legal guardian, legal representative, or any other person acting on behalf of the recipient.

i. *"Third party"* means an individual, entity, or program, excluding Medicaid, that is or

may be liable to pay all or a part of the expenditures for medical assistance provided by a Medicaid payor to the recipient. A third party includes but is not limited to all of the following:

(1) A third-party administrator.

(2) A pharmacy benefits manager.

(3) A health insurer.

(4) A self-insured plan.

(5) A group health plan, as defined in section 607(1) of the federal Employee Retirement Income Security Act of 1974.

(6) A service benefit plan.

(7) A managed care organization.

(8) Liability insurance including self-insurance.

(9) No-fault insurance.

(10) Workers' compensation laws or plans.

(11) Other parties that by law, contract, or agreement are legally responsible for payment of a claim for medical services.

j. *"Third-party benefits"* mean any benefits that are or may be available to a recipient from a third party and that provide or pay for medical services. *"Third-party benefits"* may be created by law, contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, recipient, or otherwise. *"Third-party benefits"* include but are not limited to all of the following:

(1) Benefits from collateral or proceeds.

(2) Health insurance benefits.

(3) Health maintenance organization benefits.

(4) Benefits from preferred provider arrangements and prepaid health clinics.

(5) Benefits from liability insurance, uninsured and underinsured motorist insurance, or personal injury protection coverage.

(6) Medical benefits under workers' compensation.

(7) Benefits from any obligation under law or equity to provide medical support.

3. Third-party benefits for medical services shall be primary to medical assistance provided by the Medicaid payor.

4. *a.* A Medicaid payor has all of the rights, privileges, and responsibilities identified under this section. Each Medicaid payor is a Medicaid payor to the extent of the medical assistance provided by that Medicaid payor. Therefore, Medicaid payors may exercise their Medicaid payor's rights under this section concurrently.

b. Notwithstanding the provisions of this subsection to the contrary, if the department determines that a Medicaid payor has not taken reasonable steps within a reasonable time to recover third-party benefits, the department may exercise all of the rights of the Medicaid payor under this section to the exclusion of the Medicaid payor. If the department determines the department will exercise such rights, the department shall give notice to third parties and to the Medicaid payor.

5. A Medicaid payor may assign the Medicaid payor's rights under this section, including but not limited to an assignment to another Medicaid payor, a provider, or a contractor.

6. After the Medicaid payor has provided medical assistance under the Medicaid program, the Medicaid payor shall seek reimbursement for third-party benefits to the extent of the Medicaid payor's legal liability and for the full amount of the third-party benefits, but not in excess of the amount of medical assistance provided by the Medicaid payor.

7. On or before the thirtieth day following discovery by a recipient of potential third-party benefits, a recipient or the recipient's agent, as applicable, shall inform the Medicaid payor of any rights the recipient has to third-party benefits and of the name and address of any person that is or may be liable to provide third-party benefits.

8. When the Medicaid payor provides or becomes liable for medical assistance, the Medicaid payor has the following rights which shall be construed together to provide the greatest recovery of third-party benefits:

a. The Medicaid payor is automatically subrogated to any rights that a recipient or a recipient's agent or legally liable relative has to any third-party benefit for the full amount of medical assistance provided by the Medicaid payor. Recovery pursuant to these subrogation

rights shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but shall provide full recovery to the Medicaid payor from any and all third-party benefits. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat, reduce, or prorate recovery by the Medicaid payor as to the Medicaid payor's subrogation rights granted under this paragraph.

b. By applying for, accepting, or accepting the benefit of medical assistance, a recipient or a recipient's agent or legally liable relative automatically assigns to the Medicaid payor any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

(1) The assignment granted under this paragraph is absolute and vests legal and equitable title to any such right in the Medicaid payor, but not in excess of the amount of medical assistance provided by the Medicaid payor.

(2) The Medicaid payor is a bona fide assignee for value in the assigned right, title, or interest and takes vested legal and equitable title free and clear of latent equities in a third party. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat or reduce recovery by the Medicaid payor as to the assignment granted under this paragraph.

c. The Medicaid payor is entitled to and has an automatic lien upon the collateral for the full amount of medical assistance provided by the Medicaid payor to or on behalf of the recipient for medical services furnished as a result of any covered injury or illness for which a third party is or may be liable.

(1) The lien attaches automatically when a recipient first receives medical services for which the Medicaid payor may be obligated to provide medical assistance.

(2) The filing of the notice of lien with the clerk of the district court in the county in which the recipient's eligibility is established pursuant to this section shall be notice of the lien to all persons. Notice is effective as of the date of filing of the notice of lien.

(3) If the Medicaid payor has actual knowledge that the recipient is represented by an attorney, the Medicaid payor shall provide the attorney with a copy of the notice of lien. However, this provision of a copy of the notice of lien to the recipient's attorney does not abrogate the attachment, perfection, and notice satisfaction requirements specified under subparagraphs (1) and (2).

(4) Only one claim of lien need be filed to provide notice and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by the Medicaid payor for any specific covered injury or illness. The Medicaid payor may, in the Medicaid payor's discretion, file additional, amended, or substitute notices of lien at any time after the initial filing until the Medicaid payor has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

(5) A release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall not be effective as against a lien created under this paragraph, unless the Medicaid payor joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the Medicaid payor is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the Medicaid payor may recover from the person accepting the release or satisfaction or the person making the settlement the full amount of medical assistance provided by the Medicaid payor.

(6) The lack of a properly filed claim of lien shall not affect the Medicaid payor's assignment or subrogation rights provided in this subsection nor affect the existence of the lien, but shall only affect the effective date of notice.

(7) The lien created by this paragraph is a first lien and superior to the liens and charges of any provider of a recipient's medical services. If the lien is recorded, the lien shall exist for a period of seven years after the date of recording. If the lien is not recorded, the lien shall exist for a period of seven years after the date of attachment. If recorded, the lien may be

extended for one additional period of seven years by rerecording the claim of lien within the ninety-day period preceding the expiration of the lien.

9. Except as otherwise provided in this section, the Medicaid payor shall recover the full amount of all medical assistance provided by the Medicaid payor on behalf of the recipient to the full extent of third-party benefits. The Medicaid payor may collect recovered benefits directly from any of the following:

a. A third party.

b. The recipient.

c. The provider of a recipient's medical services if third-party benefits have been recovered by the provider. Notwithstanding any provision of this section to the contrary, a provider shall not be required to refund or pay to the Medicaid payor any amount in excess of the actual third-party benefits received by the provider from a third party for medical services provided to the recipient.

d. Any person who has received the third-party benefits.

10. *a.* A recipient and the recipient's agent shall cooperate in the Medicaid payor's recovery of the recipient's third-party benefits and in establishing paternity and support of a recipient child born out of wedlock. Such cooperation shall include but is not limited to all of the following:

(1) Appearing at an office designated by the Medicaid payor to provide relevant information or evidence.

(2) Appearing as a witness at a court proceeding or other legal or administrative proceeding.

(3) Providing information or attesting to lack of information under penalty of perjury.

(4) Paying to the Medicaid payor any third-party benefit received.

(5) Taking any additional steps to assist in establishing paternity or securing third-party benefits, or both.

b. Notwithstanding paragraph *"a"*, the Medicaid payor has the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

c. The department may deny or terminate eligibility for any recipient who refuses to cooperate as required under this subsection unless the department has waived cooperation as provided under this subsection.

11. On or before the thirtieth day following the initiation of a formal or informal recovery, other than by filing a lawsuit, a recipient's attorney shall provide written notice of the activity or action to the Medicaid payor.

12. A recipient is deemed to have authorized the Medicaid payor to obtain and release medical information and other records with respect to the recipient's medical services for the sole purpose of obtaining reimbursement for medical assistance provided by the Medicaid payor.

13. *a.* To enforce the Medicaid payor's rights under this section, the Medicaid payor may, as a matter of right, institute, intervene in, or join in any legal or administrative proceeding in the Medicaid payor's own name, and in any or a combination of any, of the following capacities:

(1) Individually.

(2) As a subrogee of the recipient.

(3) As an assignee of the recipient.

(4) As a lienholder of the collateral.

b. An action by the Medicaid payor to recover damages in an action in tort under this subsection, which action is derivative of the rights of the recipient, shall not constitute a waiver of sovereign immunity.

c. A Medicaid payor, other than the department, shall obtain the written consent of the department before the Medicaid payor files a derivative legal action on behalf of a recipient.

d. When a Medicaid payor brings a derivative legal action on behalf of a recipient, the Medicaid payor shall provide written notice no later than thirty days after filing the action to the recipient, the recipient's agent, and, if the Medicaid payor has actual knowledge that the recipient is represented by an attorney, to the attorney of the recipient, as applicable.

e. If the recipient or a recipient's agent brings an action against a third party, on or before

the thirtieth day following the filing of the action, the recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice to the Medicaid payor of the action, including the name of the court in which the action is brought, the case number of the action, and a copy of the pleadings. The recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice of intent to dismiss the action at least twenty-one days before the voluntary dismissal of an action against a third party. Notice to the Medicaid payor shall be sent as specified by rule.

14. On or before the thirtieth day before the recipient finalizes a judgment, award, settlement, or any other recovery where the Medicaid payor has the right to recovery, the recipient, the recipient's agent, or the attorney of the recipient or recipient's agent, as applicable, shall give the Medicaid payor notice of the judgment, award, settlement, or recovery. The judgment, award, settlement, or recovery shall not be finalized unless such notice is provided and the Medicaid payor has had a reasonable opportunity to recover under the Medicaid payor's rights to subrogation, assignment, and lien. If the Medicaid payor is not given notice, the recipient, the recipient's agent, and the recipient's or recipient's agent's attorney are jointly and severally liable to reimburse the Medicaid payor for the recovery received to the extent of medical assistance paid by the Medicaid payor. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

15. *a.* Except as otherwise provided in this section, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the Medicaid payor's claim for reimbursement of the amount of medical assistance provided and any lien pursuant to the claim.

b. Insurance and other third-party benefits shall not contain any term or provision which purports to limit or exclude payment or the provision of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance, and any such term or provision shall be void as against public policy.

16. In an action in tort against a third party in which the recipient is a party and which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

a. After deduction of reasonable attorney fees, reasonably necessary legal expenses, and filing fees, there is a rebuttable presumption that all Medicaid payors shall collectively receive two-thirds of the remaining amount recovered or the total amount of medical assistance provided by the Medicaid payors, whichever is less. A party may rebut this presumption in accordance with subsection 17.

b. The remaining recovered amount shall be paid to the recipient.

c. If the recovered amount available for the repayment of medical assistance is insufficient to satisfy the competing claims of the Medicaid payors, each Medicaid payor shall be entitled to the Medicaid payor's respective pro rata share of the recovered amount that is available.

17. *a.* A recipient or a recipient's agent who has notice or who has actual knowledge of the Medicaid payor's rights to third-party benefits under this section and who receives any third-party benefit or proceeds for a covered injury or illness shall on or before the sixtieth day after receipt of the proceeds pay the Medicaid payor the full amount of the third-party benefits, but not more than the total medical assistance provided by the Medicaid payor, or shall place the full amount of the third-party benefits in an interest-bearing trust account for the benefit of the Medicaid payor pending a determination of the Medicaid payor's rights to the benefits under this subsection.

b. If federal law limits the Medicaid payor to reimbursement from the recovered damages for medical expenses, a recipient may contest the amount designated as recovered damages for medical expenses payable to the Medicaid payor pursuant to the formula specified in subsection 16. In order to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as medical expenses, including future medical expenses, is

less than the amount calculated by the Medicaid payor pursuant to the formula specified in subsection 16. Alternatively, to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that Medicaid provided a lesser amount of medical assistance than that asserted by the Medicaid payor. A settlement agreement that designates the amount of recovered damages for medical expenses is not clear and convincing evidence and is not sufficient to establish the recipient's burden of proof, unless the Medicaid payor is a party to the settlement agreement.

c. If the recipient or the recipient's agent filed a legal action to recover against the third party, the court in which such action was filed shall resolve any dispute concerning the amount owed to the Medicaid payor, and shall retain jurisdiction of the case to resolve the amount of the lien after the dismissal of the action.

d. If the recipient or the recipient's agent did not file a legal action, to resolve any dispute concerning the amount owed to the Medicaid payor, the recipient or the recipient's agent shall file a petition for declaratory judgment as permitted under **rule of civil procedure 1.1101** on or before the one hundred twenty-first day after the date of payment of funds to the Medicaid payor or the date of placing the full amount of the third-party benefits in a trust account. Venue for all declaratory actions under this subsection shall lie in Polk county.

e. If a Medicaid payor and the recipient or the recipient's agent disagree as to whether a medical claim is related to a covered injury or illness, the Medicaid payor and the recipient or the recipient's agent shall attempt to work cooperatively to resolve the disagreement before seeking resolution by the court.

f. Each party shall pay the party's own attorney fees and costs for any legal action conducted under this subsection.

18. Notwithstanding any other provision of law to the contrary, when medical assistance is provided for a minor, any statute of limitation or repose applicable to an action or claim of a legally responsible relative for the minor's medical expenses is extended in favor of the legally responsible relative so that the legally responsible relative shall have one year from and after the attainment of the minor's majority within which to file a complaint, make a claim, or commence an action.

19. In recovering any payments in accordance with this section, the Medicaid payor may make appropriate settlements.

20. If a recipient or a recipient's agent submits via notice a request that the Medicaid payor provide an itemization of medical assistance paid for any covered injury or illness, the Medicaid payor shall provide the itemization on or before the sixty-fifth day following the day on which the Medicaid payor received the request. Failure to provide the itemization within the specified time shall not bar a Medicaid payor's recovery, unless the itemization response is delinquent for more than one hundred twenty days without justifiable cause. A Medicaid payor shall not be under any obligation to provide a final itemization until a reasonable period of time after the processing of payment in relation to the recipient's receipt of final medical services. A Medicaid payor shall not be under any obligation to respond to more than one itemization request in any one-hundred-twenty-day period. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

21. The department may adopt rules to administer this section and applicable federal requirements.

[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

2023 Acts, ch 158, §2

Referred to in §249A.37

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

249A.58 Cooperation with child support services.

1. Unless exempt pursuant to state or federal law or regulation, an applicant for or recipient of medical assistance shall be required to cooperate with child support services as a condition of eligibility.

2. The department shall adopt rules pursuant to chapter 17A to administer this section.

2023 Acts, ch 104, §11