249A.4 Duties of director.

The director shall be responsible for the effective and impartial administration of this chapter and shall, in accordance with the standards and priorities established by this chapter, by applicable federal law, by the regulations and directives issued pursuant to federal law, by applicable court orders, and by the state plan approved in accordance with federal law, make rules, establish policies, and prescribe procedures to implement this chapter. Without limiting the generality of the foregoing delegation of authority, the director is hereby specifically empowered and directed to:

1. Determine the greatest amount, duration, and scope of assistance which may be provided, and the broadest range of eligible individuals to whom assistance may effectively be provided, under this chapter within the limitations of available funds. In so doing, the director shall at least every six months evaluate the scope of the program currently being provided under this chapter, project the probable cost of continuing a like program, and compare the probable cost with the remaining balance of the state appropriation made for payment of assistance under this chapter during the current appropriation period. After each evaluation of the scope of the program, the director shall report to the general assembly through the legislative council or in another manner as the general assembly may by resolution direct.

2. Reserved.

3. Have authority to provide for payment under this chapter of assistance rendered to any applicant prior to the date the application is filed.

4. Have authority to contract with any corporation authorized to engage in this state in insuring groups or individuals for all or part of the cost of medical, hospital, or other health care or with any corporation maintaining and operating a medical, hospital, or health service prepayment plan under the provisions of chapter 514 or with any health maintenance organization authorized to operate in this state, for any or all of the benefits to which any recipients are entitled under this chapter to be provided by such corporation or health maintenance organization on a prepaid individual or group basis.

5. May, to the extent possible, contract with a private organization or organizations whereby such organization will handle the processing of and the payment of claims for services rendered under the provisions of this chapter and under such rules and regulations as shall be promulgated by such department. The state department may give due consideration to the advantages of contracting with any organization which may be serving in Iowa as "intermediary" or "carrier" under Tit. XVIII of the federal Social Security Act, as amended.

6. Shall cooperate with any agency of the state or federal government in any manner as may be necessary to qualify for federal aid and assistance for medical assistance in conformity with the provisions of chapter 249, this chapter, and Tit. XVI and XIX of the federal Social Security Act, as amended.

7. Shall provide for the professional freedom of those licensed practitioners who determine the need for or provide medical care and services, and shall provide freedom of choice to recipients to select the provider of care and services, except when the recipient is eligible for participation in a health maintenance organization or prepaid health plan which limits provider selection and which is approved by the department.

a. However, this shall not limit the freedom of choice to recipients to select providers in instances where such provider services are eligible for reimbursement under the medical assistance program but are not provided under the health maintenance organization or under the prepaid health plan, or where the recipient has an already established program of specialized medical care with a particular provider. The department may also restrict the recipient's selection of providers to control the individual recipient's overuse of care and services, provided the department can document this overuse. The department shall promulgate rules for determining the overuse of services, including rights of appeal by the recipient.

b. Advanced registered nurse practitioners licensed pursuant to chapter 152 and physician assistants licensed pursuant to chapter 148C shall be regarded as approved providers of health care services, including primary care, for purposes of managed care or

prepaid services contracts under the medical assistance program. This paragraph shall not be construed to expand the scope of practice of an advanced registered nurse practitioner pursuant to chapter 152 or physician assistants pursuant to chapter 148C.

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

9. Adopt rules pursuant to chapter 17A in determining the method and level of reimbursement for all medical and health services to be provided under the medical assistance program, after considering all of the following:

a. The promotion of efficient and cost-effective delivery of medical and health services.

b. Compliance with federal law and regulations.

c. The level of state and federal appropriations for medical assistance.

d. Reimbursement at a level as near as possible to actual costs and charges after priority is given to the considerations in paragraphs "*a*", "*b*", and "*c*".

10. *a.* Allow supplementation of the combination of client participation and payment made through the medical assistance program for those items and services identified in 42 C.F.R. §483.10(c)(8)(ii), by the resident of a nursing facility or the resident's family. Supplementation under this subsection may include supplementation for provision of a private room not otherwise covered under the medical assistance program unless either of the following applies:

(1) The private room is therapeutically required pursuant to 42 C.F.R. §483.10(c)(8)(ii).

(2) No room other than the private room is available.

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

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

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

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

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

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

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

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

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

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

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

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

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

room rate for the type of rooms covered under the medical assistance program for which the resident would be eligible.

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

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

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

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

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

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

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

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

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

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

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

11. Shall provide an opportunity for a fair hearing before the department of inspections and appeals to an individual whose claim for medical assistance under this chapter is denied or is not acted upon with reasonable promptness. Upon completion of a hearing, the department of inspections and appeals shall issue a decision which is subject to review by the department of human services. Judicial review of the decisions of the department of human services may be sought in accordance with chapter 17A. If a petition for judicial review is filed, the department of human services shall furnish the petitioner with a copy of the application and all supporting papers, a transcript of the testimony taken at the hearing, if any, and a copy of its decision.

12. In determining the medical assistance eligibility of a pregnant woman, infant, or child under the federal Social Security Act, §1902(l), resources which are used as tools of the trade shall not be considered.

13. In implementing subsection 9, relating to reimbursement for medical and health services under this chapter, when a selected out-of-state acute care hospital facility is involved, a contractual arrangement may be developed with the out-of-state facility that is in accordance with the requirements of Tit. XVIII and XIX of the federal Social Security Act. The contractual arrangement is not subject to other reimbursement standards, policies, and rate setting procedures required under this chapter.

14. A medical assistance copayment shall only be applied to those services and products specified in administrative rules of the department in effect on February 1, 1991, which under federal medical assistance requirements, are provided at the option of the state.

15. Establish appropriate reimbursement rates for community mental health centers that are accredited by the mental health and disability services commission.

[C62, 66, §249A.5, 249A.10; C71, 73, 75, 77, 79, 81, §249A.4; 82 Acts, ch 1260, §121, 122] 83 Acts, ch 96, §157, 159; 83 Acts, ch 153, §12, 13; 83 Acts, ch 201, §13; 86 Acts, ch 1245, §2031; 89 Acts, ch 37, §1; 89 Acts, ch 104, §5; 89 Acts, ch 304, §203; 90 Acts, ch 1204, §61, 62; 90 Acts, ch 1223, §21; 90 Acts, ch 1256, §41; 90 Acts, ch 1264, §34; 91 Acts, ch 97, §32; 91 Acts, ch 158, §5; 92 Acts, ch 1229, §29, 30; 94 Acts, ch 1150, §1, 2; 97 Acts, ch 165, §1; 98 Acts, ch 1181, §4; 99 Acts, ch 96, §27; 2000 Acts, ch 1029, §1, 2; 2001 Acts, ch 24, §65, 74; 2001 Acts, ch 74, §17; 2003 Acts, ch 21, §1; 2004 Acts, ch 1090, §14; 2005 Acts, ch 120, §2; 2005 Acts, ch 167, §46, 66; 2009 Acts, ch 41, §243; 2009 Acts, ch 118, §18; 2010 Acts, ch 1031, §389; 2012

Acts, ch 1034, §1; 2013 Acts, ch 138, §72; 2014 Acts, ch 1140, §87, 88; 2020 Acts, ch 1020, §8, 12; 2020 Acts, ch 1063, §94
Referred to in §249A.3
Subsection 7, paragraph b amended
Subsections 11 and 15 amended