Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 80
"Procedure and Method of Payment"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Purpose and Summary

This proposed rulemaking provides guidance on claim format and submission for providers of medical and remedial care that participate in Iowa's medical assistance program.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Health care providers participating in Iowa Medicaid will benefit from the guidance contained in this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

In SFY 2024, the Department received 14,758,588 claims and reimbursed $5,106,587,377.84 for services provided to covered Iowans.

- **Qualitative description of impact:**

This proposed rulemaking describes the specific requirements for submitting claims. Without this guidance, participating providers would not be able to be reimbursed properly for services provided to members.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement the proposed chapter.

- **Anticipated effect on State revenues:**

The proposed chapter has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required by law.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Rulemaking is required by law.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Rulemaking is required by law.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 80 and adopt the following **new** chapter in lieu thereof:

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT

441—80.1(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to Iowa Medicaid on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after the end of the calendar month in which the services are provided. Following audit of the claim, Iowa Medicaid will make payment to the provider of care. The provider manual, Chapter IV, Billing Iowa Medicaid, found on the department's website and as amended to July 1, 2026, will detail the specific manner and frequency in which claims are to be submitted.

80.1(1) Electronic submission. Providers are required to submit claims electronically whenever possible.

80.1(2) For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to Iowa Medicaid must submit the following electronically, in accordance with the All Providers manual, Chapter IV, Billing Iowa Medicaid, located on the department's website and as amended to July 1, 2026:

a. Form UB-04.

b. Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by Iowa Medicaid.

441—80.2(249A) Payment from other sources. This rule applies to claims for the department, managed care organizations, and the Public Health Associate Program (PHAP).

80.2(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source will be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.2(2) *Third-party liability.*

a. When a third-party liability for medical expenses exists, this resource will be utilized for payment of a claim before the Medicaid program makes payment unless:

(1) The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

1. Preventive pediatric services, and
2. All services provided to a person for whom there is court-ordered medical support.

(2) Otherwise authorized by the department.

b. All claims must be clean claims. A clean claim is defined as a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim.

80.2(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. No later than 60 days after receiving any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service, respond to such inquiry, pursuant to 42 U.S.C. Section 1396a(25)(I)(iii) as amended to July 1, 2026.

b. Agree not to deny any claim submitted by the state solely because 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 responsible third party (other than the original Medicare fee-for-service program under Parts A and B of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a Medicare Advantage plan offered by a Medicare Advantage organization under Part C of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a reasonable cost of reimbursement plan under 42 U.S.C. Section 1395mm as amended to July 1, 2026, a health care prepayment plan under 42 U.S.C. Section 1395l as amended to July 1, 2026, or a prescription drug plan (PDP) offered by a PDP sponsor under Part D of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026), a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

d. Agree not to deny any claim submitted by the state solely because of lack of prior authorization.

441—80.3(249A) Time limit for submission of claims and claim adjustments.

80.3(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by Iowa Medicaid exceeds 365 days. The department will consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.3(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by Iowa Medicaid within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.3(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

441—80.4(249A) Authorization process.

80.4(1) *Identification cards.* The department will issue a medical assistance eligibility card to members for use in securing medical and health services available under the program except as provided in 441—Chapter 76.

a. The department will issue the medical assistance eligibility card:

(1) When the member's eligibility is initially determined.

(2) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The medical assistance eligibility card is valid only for months in which the member has established eligibility as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.4(2) Reserved.

441—80.5(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below.

80.5(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with 441—Chapter 75.

80.5(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.5(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

441—80.6(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406 as amended to July 1, 2026), service benefit plans, managed care organizations, pharmacy benefits managers, and other

parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.6(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. A data use agreement shall prescribe the specific detail elements required, any privacy protections, the manner in which information shall be provided to the department or its designee, and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department or its designee to match covered persons and identify third-party payors for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.6(2) *Confidentiality of data.* The exchange of information carried out under this rule 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:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended to July 1, 2026; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164 as amended to July 1, 2026.

These rules are intended to implement Iowa Code chapter 249A.