Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 79
"Other Policies Relating to Providers of Medical and Remedial Care"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 124 and 249A and Public Laws 111.5 and 109-177

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 chapter provides information for providers about Iowa's Medicaid program, including the following:

- Provider reimbursement methodology;
- Provider sanctions;
- Medical record maintenance;
- Reviews and audits;
- Provider agreements;
- The Medical Assistance Advisory Council;
- Requirements for prior-authorization, pre-admission review, and pre-procedure surgical review;
- Provider enrollment;
- Requirements for participating laboratories; and
- Requirements for providers prescribing controlled substances.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of its review, the Department eliminated restrictive terms; outdated terminology, information, dates, and system references; added dates certain; standardized references to the Department pursuant to government realignment; and updated provisions to match current Department practice and policy. The Department also deleted references to Iowa Code sections repealed by 2024 Iowa Acts, House File 2673.

Analysis of Impact

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

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

Health care providers may incur administrative costs to comply with this proposed chapter.

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

Health care providers that participate or apply for participation in Iowa's Medicaid program, as well as Iowa Medicaid members, will benefit from the guidance and structure provided in this proposed chapter.

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:**

As of June 23, 2025, Iowa Medicaid has 72,358 participating providers representing 69 distinct provider types.

- **Qualitative description of impact:**

This proposed chapter provides needed information to providers that participate in Iowa Medicaid or that want to apply to participate in Iowa Medicaid.

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 enforce this proposed chapter.

- **Anticipated effect on State revenues:**

This 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:**

This proposed rulemaking is both required and needed in order to maintain a network of health care providers meeting State and federal standards and requirements.

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

Not applicable.

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:**

Not applicable.

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 proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 79 and adopt the following **new** chapter in lieu thereof:

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" or "MCO" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per unit rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made on July 1 of each year.

There are some variations in this methodology that are applicable to certain providers. These are set forth below in subrules 79.1(3) through 79.1(8) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website.

d. Reserved.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers that have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers that have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to paragraph 79.1(15)*"f."*

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs will be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h"* for more information.

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

i. Inflation factor. When the department's reimbursement methodology for any provider includes an inflation factor, this inflation factor will not exceed the amount by which the consumer price index for all urban consumers increased during the most recent calendar year.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 7/1/21.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Applied behavior analysis	Fee schedule	Fee schedule in effect 7/1/22.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/22.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule. See 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: $21.11 per 15-minute unit.
Community mental health centers	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1,

Provider category	Basis of reimbursement	Upper limit
		2026, or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and an MCO, reimbursement from the MCO will be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule	Effective 7/1/22, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/22 rate: Veterans Administration contract rate or $1.58 per 15-minute unit, $25.33 per half day, $50.44 per full day, or $75.63 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22, for intellectual disability waiver: The provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute or half-day rate. If no 6/30/22 rate, $2.12 per 15-minute unit or $33.76 per half day. For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: Initial one-time fee: $56.18. Ongoing monthly fee: $43.69.
Portable locator system	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: Initial one-time fee: $56.18. Ongoing monthly fee: $43.69.
3. Home health aides	Fee schedule	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25% or maximum Medicaid rate in effect 6/30/22 plus 4.25%. For intellectual disability waiver effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25% or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted

Provider category	Basis of reimbursement	Upper limit
		to a 15-minute rate. If no 6/30/22 rate: $5.61 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $94.98 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, not to exceed $340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, not to exceed $340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $9.67 per 15-minute unit, not to exceed $340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.16 per 15-minute unit, not to exceed $340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $9.67 per 15-minute unit, not to exceed $340.15 per day.
Basic individual respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.16 per 15-minute unit, not to exceed $340.15 per day.
Group respite	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted

Provider category	Basis of reimbursement	Upper limit
		to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed $340.15 per day.
Adult day care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $4.37 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $8.75 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/22: $1,145.48 lifetime maximum. For intellectual disability waiver effective 7/1/22: $5,727.37 lifetime maximum.

Provider category	Basis of reimbursement	Upper limit
		For brain injury, health and disability, and physical disability waivers effective 7/1/22: $6,872.85 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Fee schedule in effect 7/1/22.
12. Nutritional counseling	Fee schedule	Effective 7/1/22 for non-county contract: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $9.46 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/22: $124.81 per unit.
14. Senior companion	Fee schedule	Effective 7/1/22 for non-county contract: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $2.04 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.78 per 15-minute unit, not to exceed $133.70 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $5.78 per 15-minute unit, not to exceed $133.70 per day.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $12.36 per 15-minute unit.
Group	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $12.35 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/22, provider's rate in effect 6/30/22 plus 4.25%.
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/22: $10.02 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 11.727%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/22: $10.02 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30) .
19. Supported employment:		

Provider category	Basis of reimbursement	Upper limit
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/22. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/22, $6,872.85 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $12.36 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $12.35 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/22.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Fee schedule	Effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Fee schedule	Effective 7/1/22: Lesser of maximum Medicare rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $10.02 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 11.727%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22: The fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/22: Provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.78 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30).

Provider category	Basis of reimbursement	Upper limit
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/22, $6,872.85 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $10.02 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $26.82 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $74.46 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%. If no 6/30/22 rate: $17.35 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	$28.16 per day.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule	Effective 7/1/22: Fee schedule in effect 6/30/22 plus 4.25%.
2. Home-based habilitation	Fee schedule	Fee schedule in effect 7/1/22.
3. Day habilitation	Fee schedule	Effective 7/1/22: $3.57 per 15-minute unit or $69.40 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect 7/1/22.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported

Provider category	Basis of reimbursement	Upper limit
		employment services not to exceed $3,302.53 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/22. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Individual placement and support supported employment	Fee schedule	Fee schedule in effect 7/1/22. Total monthly cost for all supported employment services not to exceed $3,302.53 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.5(11)*"q"*	Effective 7/1/22: The Medicaid LUPA fee schedule rate published on the department's website.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 10/1/2021.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 1/1/2021.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)*"h"*	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare).
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.4(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and	Fee schedule in effect 6/30/13 plus 1%.

Provider category	Basis of reimbursement	Upper limit
	statistical data submitted annually by the provider group	
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—81.5(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.5(16)*"f"*(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.5(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—81.5(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.5(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q."*	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other	Fee schedule in effect 6/30/13 plus 1%.

Provider category	Basis of reimbursement	Upper limit
	optical materials at product acquisition cost	
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q."*	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)*"d"*	Fee schedule in effect 7/1/17. See 79.1(7)*"d."*
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)*"c"*	Rate provided by 79.1(7)*"c."*
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children: 1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/21: Non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q."*	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and an MCO, reimbursement from the MCO will be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment will be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)*"n."*

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" means a Medicaid patient 17 years or younger.

"Adult" means a Medicaid patient 18 years or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2019, and before January 1, 2020, except as noted in paragraph 79.1(5)*"x."* Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" means the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount will be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" means case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report will not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" means an add-on to the blended base amount, which will compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80

percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" means an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" means hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" means cases that have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections, appeals, and licensing pursuant to rule 481—51.27(135B).

"Diagnosis-related group (DRG)" means a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs will be made from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by a factor to maintain expenditures within the amount

appropriated to the department for this purpose. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" means a payment that will compensate for treatment of a disproportionate share of poor patients. The disproportionate share payment will be made directly from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

"Disproportionate share percentage" means either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See subparagraph 79.1(5)*"y"*(7) for more information.)

A separate disproportionate share percentage will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case, coded as a transfer to another hospital, will be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report period. The claim set is updated in July of every third year and is modeled using recalibrated rates pursuant to paragraph 79.1(5)*"r."*

"GME/DSH fund implementation year" means 2022.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" means a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate will be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of

full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" means those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" means cases that have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in paragraph 79.1(5)*"f."*

"Low-income utilization rate" means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate will be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2018, through December 31, 2019, and paid through March 31, 2020.

"Medicaid inpatient utilization rate" means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate will be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" means a designated level II or level III neonatal unit.

"Net discharges" means total discharges minus transfers and short stay outliers.

"Rate table listing" means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by a hospital before being multiplied by the appropriate DRG weight.

"Rebasing" means the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2021 and every three years thereafter.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" means cases that have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in paragraph 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to paragraph 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The

second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to paragraph 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2021, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid cost data less medical education from the Medicaid claim set using trimmed claims. Medicaid cost data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions pursuant to paragraph 79.1(5)*"b."* Weights are determined through the following calculations:

1. Determine the statewide geometric mean cost for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean cost for each DRG by multiplying the statewide geometric mean cost for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean costs for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean cost for all DRGs.
4. Divide the statewide geometric mean cost for each DRG by the weighted average geometric mean cost for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index will be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation will use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose:

1. The total calculated dollar expenditures based on hospitals' base year cost reports for capital costs and medical education costs, multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base year cost report or MMIS claims system, the actual dollar expenditures for capital costs, and direct medical education costs multiplied by an amount to maintain expenditures within the amount appropriated to the department for this purpose, and then subtracting payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge will be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base year cost report by 80 percent and then multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs will be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid

patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Reserved.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. One hundred percent of outlier costs will be paid to facilities at the time of claim reimbursement. Iowa Medicaid will perform retrospective outlier reviews.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers will be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to Iowa Medicaid review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts will be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by Iowa Medicaid must submit all requested supporting data to Iowa Medicaid within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to Iowa Medicaid within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units.

When a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay will be combined with the claim for the original inpatient stay and payment will be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units, psychiatric units, and acute psychiatric intensive care services. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base year per diem rate to which a factor to maintain expenditures within the amount appropriated to the department for this purpose is applied.

(1) Per diem calculation. The base rate will be the medical assistance per diem rate as determined by the individual hospital's base year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Per diem reimbursement. Hospitals will be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate will be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(3) Per diem recalculation. Hospital prospective reimbursement rates will be established based on the state's fiscal year.

(4) Acute psychiatric intensive care services. Services that meet the criteria at 441—subrule 78.3(8) will be reimbursed as follows:

1. Services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific per diem rate as calculated pursuant to subparagraph 79.1(5)*"i"*(1) plus a percentage increase as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

2. Services not provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific DRG payment rate as calculated pursuant to paragraph 79.1(5)*"b"* plus an add-on per diem rate as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

(5) Per diem billing. The current method for submitting billing and cost reports will be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415 as amended to July 1, 2026, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment.

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors will be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts will be rebased and weights recalibrated in 2021 and every three years thereafter. Cost reports used in rebasing will be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to Iowa Medicaid by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund will be updated as provided in subparagraphs 79.1(5)*"y"*(3), *"y"*(6), and *"y"*(9).

(4) Hospitals receiving reimbursement as critical access hospitals will not receive inflation of base payment amounts and will not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Out-of-state hospitals do not qualify for disproportionate share payments.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that Iowa Medicaid reviews short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by Iowa Medicaid. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly to Iowa Medicaid and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through Iowa Medicaid will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to Iowa Medicaid after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by Iowa Medicaid as described in paragraph 79.1(5)*"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to Iowa Medicaid at the department's address. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by Iowa Medicaid, reimbursement will be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* will be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by Iowa Medicaid to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid at the department's address, with documentation that the certification requirements are met. Iowa Medicaid will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital will be retroactive to the first day of the month during which Iowa Medicaid received the request for certification. No additional retroactive payment adjustment will be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)*"b"*(1) if the unit's program is licensed by the department as a substance abuse treatment program in accordance with Iowa Code chapter 125. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under subparagraph 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission or the American Osteopathic Association. Iowa Medicaid will verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the department pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if the physical rehabilitation hospital or unit receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 CFR Subpart P as amended to July 1, 2026, and the hospital is accredited by the Joint Commission or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36 has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272, both as amended to July 1, 2026.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American Council on Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $0.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital

disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. Reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15) as amended to July 1, 2026. Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment will be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights pursuant to paragraph 79.1(5)*"r"* for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights, pursuant to paragraph 79.1(5)*"r,"* for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph 79.5(1)*"y"*(10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals or (2) 2 ½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage will be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition but do not qualify under the low-income utilization rate definition, the disproportionate share percentage will be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage will be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act as amended to July 1, 2026, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital will be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights, pursuant to paragraph 79.1(5)*"r,"* for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights, pursuant to 79.1(5)*"r,"* for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age will be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234 as amended to July 1, 2026) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments, pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v,"* cannot exceed the amount of the federal cap under Public Law 102-234 as amended to July 1, 2026.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions.

A hospital wishing to qualify for disproportionate share payments as a children's hospital must provide the following information to Iowa Medicaid within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Reserved.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals, pursuant to paragraphs 79.1(5)*"a"* through *"z,"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* through *"z."* Amounts paid before adjustment that exceed reasonable costs will be recovered by the department.

(1) The base rate upon which the DRG payment is built will be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to Iowa Medicaid and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment will not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv) as amended to July 1, 2026, if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share will be funds generated from tax levy collections of the county or city in which the hospital is located and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year will apply.

(3) Amount of payment. The total amount of disproportionate share payments made, pursuant to paragraph 79.1(5)*"y,"* and the rural hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American

Medical Association as amended to July 1, 2026. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the CPT as amended to July 1, 2026. Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* will be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting as opposed to the physician's office. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following (consistent with "POS" definitions under Medicare per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, amended to July 1, 2026):

(1) Telehealth (POS 02).
(2) Outpatient hospital-off campus (POS 19).
(3) Inpatient hospital (POS 21).
(4) Outpatient hospital-on campus (POS 22).
(5) Emergency room-hospital (POS 23).
(6) Ambulatory surgical center (POS 24).
(7) Military treatment center (POS 26).
(8) Skilled nursing facility (POS 31).
(9) Hospice-for inpatient care (POS 34).
(10) Ambulance-land (POS 41).
(11) Ambulance-air or water (POS 42).
(12) Inpatient psychiatric facility (POS 51).
(13) Psychiatric facility-partial hospitalization (POS 52).
(14) Community mental health center (POS 53).
(15) Psychiatric residential treatment center (POS 56).
(16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. Primary care services that are eligible for payment, pursuant to this rule, will be paid at the greater of:

(1) The otherwise applicable Iowa Medicaid rate;

(2) The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

(3) The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009; or

(4) If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the CMS, pursuant to 42 CFR §447.405(a)(1), and in effect on June 30, 2014.

Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the Vaccines for Children Program will be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)*"c."* Anesthesia procedures listed in the fee schedule with a factor code of "F" are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee

schedule with a factor code of "A" are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. The Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount, which will be updated annually on January 1.

79.1(8) *Drugs.*

a. Except as provided in paragraphs 79.1(8)*"d"* through *"h,"* all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*;

2. The federal upper limit (FUL), defined as the upper limit for a multiple-source drug established in accordance with the methodology of CMA as described in 42 CFR 447.514(a)-(c) as amended to July 1, 2026, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"c"*;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*; or

4. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state-defined professional dispensing fee; or

3. Providers' usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC will be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys will be conducted at least once every six months or more often at the department's discretion. The average state AAC will be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department will be published on the department's website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span will be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee will be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey will be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose will be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)*"a,"* reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

2. The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, will be according to paragraph 79.1(8)*"a"* because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c";*

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 as amended to July 1, 2026, will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)*"a"* through *"f."* The pharmacy encounter rate is the current "outpatient per visit rate (excluding Medicare)" approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)*"a"* through *"f,"* payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, will be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment will be made for sales tax.

k. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) Reserved.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider will be made to anyone other than the providers. However, with respect to physicians, dentists or other individual practitioners, direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization, including a health maintenance organization that furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, that renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule will preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers, as specified in subrule 79.1(1), will not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau that, or an individual who, advances money to a provider for accounts receivable that have been assigned or sold or otherwise transferred, including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives, such as billing agents or accounting firms, that render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which, in the judgment of the Secretary of the Department of Health and Human Services, generally do not vary significantly in quality from one provider to another, the upper limits for payments will be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits will be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits will be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department will pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department will pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified will be charged to members for the following covered services:

a. The member shall pay a copayment of $1 for each covered prescription or refill of any covered drug.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment will not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility, the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate will be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care will be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) will not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS children's mental health waiver family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency under an HCBS intellectual disability waiver, brain injury waiver, or health and disability waiver.

a. Reporting requirements.

(1) Providers shall submit the completed certification form prescribed by the department. The provider shall email the report and required supplemental information to the email address specified on the form. The provider shall mail one signed copy of the certification page to Iowa Medicaid at the department's address, no later than the due date of the required electronic submissions.

(2) The provider shall submit a financial and statistical report coinciding with the provider's fiscal year.

(3) The provider shall submit the financial and statistical report on or before the last day of the third month following the end of the cost reporting period.

(4) A certified home health agency enrolled to deliver HCBS that is required to submit a Medicare cost report may request a 60-day extension for submitting the financial and statistical cost report. All other providers may request a 30-day extension for submitting the financial and statistical report. All requests must be submitted in writing to Iowa Medicaid by the financial and statistical report due date. No other extensions will be granted.

(5) If a provider terminates its participation in any HCBS program or service, the provider shall submit a final financial and statistical report on or before the sixtieth day following the date of termination for retrospective adjustment in accordance with subparagraph 79.1(15)*"f"*(1).

(6) Providers failing to submit a financial and statistical report that meets the requirements of this paragraph within the time frames set forth in subparagraph 79.1(1)*"a"*(3) or *"a"*(4), as applicable, will reduce payment to 76 percent of the current rate. The reduced rate will be paid for not longer than three months, after which time no further payments will be made.

(7) Providers shall submit a completed financial and statistical report in an electronic format that can be opened using the extension xls or xlsx. The provider shall submit supplemental documentation in a generally accepted business format.

(8) Along with its financial and statistical report, the provider shall include a working trial balance that corresponds to the data contained on the financial and statistical report. Financial and statistical reports submitted without a working trial balance will be considered incomplete.

(9) The provider's financial data within the financial and statistical report shall be based on the provider's financial records. When the records are not based on the accrual basis of accounting, the provider shall make adjustments necessary to convert the information to an accrual basis for reporting.

(10) Providers of multiple programs or services shall submit a cost allocation schedule. The schedule must identify an allocation method for each expense account, including the statistics used in the calculation.

(11) Providers shall not report costs to any waiver service that are costs of any other program or public or private funding sources, including but not limited to the Medicaid state plan; Medicare; other state, local or federal funded programs; and private funding sources. Providers shall not report costs of HCBS waiver services as a cost of any other public or private funding source.

(12) Iowa Medicaid or its designee may review or audit financial and statistical reports as filed to determine the actual cost of services in accordance with generally accepted accounting principles or Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, subject to the exceptions and limitations in the department's administrative rules and financial and statistical report instructions.

(13) Failure to maintain records to support the financial and statistical report and make them available to the department or its designee upon request may result in adjustment, payment reduction, or sanction including but not limited to termination of the provider's HCBS certification.

(14) When adjustments made to prior reports indicate noncompliance with reporting instructions or the provider has a history of inadequate documentation to support the financial and statistical report, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on the form specified by the department and have an approved service plan for the member.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Twenty percent identified cost limitation.

1. The following identified costs are not subject to the 20 percent limitation; however, the following costs are used to calculate the limitation:

- Wages, benefits, and payroll taxes.
- Direct care transportation expense—with and without member present.
- Direct care development, training, and supplies.
- Member-specific assistance.
- Member-specific equipment repair or purchase.

2. For each waiver service, the sum of reported costs not identified in numbered paragraph 79.1(15)*"b"*(3)"1" is limited to 20 percent of the identified costs in numbered paragraph 79.1(15)*"b"*(3)"1."

(4) Mileage reimbursement for business use of personal employee vehicles will be limited to the federal Internal Revenue Service's (IRS's) published mileage rate in effect during the cost reporting period.

(5) Compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function and do not exceed the maximum allowed compensation as described in numbered paragraphs 79.1(15)*"b"*(5)"5" and "6."

1. "Ownership" is defined as an interest of 5 percent or more. For this purpose, the following persons are considered immediate relatives: husband, wife, natural or adoptive parent, natural or adoptive child, natural or adoptive sibling, step-parent, step-child, step-sibling, parent-in-law, child-in-law, sibling-in-law, grandparent, or grandchild. Adequate time records shall be maintained.

2. "Compensation" means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred

compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest-issued W-2 and current compensation shall be required to be disclosed to Iowa Medicaid or its designee. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation will be considered unallowable for reimbursement. Providers shall report all compensation paid to related parties, including payroll taxes, on the financial and statistical report.

3. "Reasonableness" requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable providers, and depends upon the facts and circumstances of each case.

4. "Necessary" requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service and be pertinent to the operation and sound conduct of the institution.

5. The maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, is equal to the intermediate care facility for persons with an intellectual disability (ICF/ID) maximum compensation for facilities with 60 beds or more pursuant to 441—subparagraph 82.4(11)*"e"*(4).

6. The maximum allowed compensation for any other owner or immediate relative is 60 percent of the amount allowed in numbered paragraph 79.1(15)*"b"*(5)"5."

7. The provider shall maintain records in the same manner for an owner or immediate relative compensated by the agency as are maintained for any employee of the agency, including but not limited to employment records, timekeeping, and payroll records.

8. The maximum allowed compensation for owners and immediate relatives shall be adjusted by the percentage of the average workweek devoted to business activity during the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one owner or immediate relative allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one agency.

9. Costs applicable to services, facilities, and supplies furnished to the provider by a person or organization related to the provider by common ownership or control are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

- "Related" means that the agency, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
- Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.
- Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.
- A provider may lease a facility from a related person or organization. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its cost the costs of ownership of the facility. This includes depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.
- An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence that the criteria in numbered paragraph 79.1(15)*"b"*(5)"10" have been met.

10. The agency must demonstrate the following with convincing evidence. Where all of the conditions below are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

- The supplying organization is a bona fide separate organization;

- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and
- The charge to the agency is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

c. Prospective rates for new providers.

(1) "New providers" means providers who have not submitted an annual report including at least six months of actual, historical costs of operations for any service as listed in subrule 79.1(15).

(2) New providers will be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period.

(3) Projected costs of any new service, as listed in subrule 79.1(15), shall be submitted on the applicable form prescribed by the department.

(4) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

(5) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates will be determined as provided in paragraph 79.1(15)*"d."*

d. Prospective rates for established providers.

(1) "Established providers" means providers who have submitted an annual report including six months of actual, historical costs of operation.

(2) The prospective rate will be adjusted annually, effective the first day of the third month after the month during which the annual financial and statistical report is submitted to the department.

(3) The provider's prospective rate will be the lower of:

1. The provider's reasonable and proper actual cost-based rate as calculated by the provider's most recent financial and statistical report and adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end,

2. In the first year of reporting six months of actual, historical costs of operation, or a year in which the provider's base rate is recalculated, the base rate is equal to the amount calculated in numbered paragraph 79.1(15)*"d"*(3)"1,"

3. In a year in which the provider's base rate is not recalculated, the prior period base rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end, or

4. The upper rate limit pursuant to subrule 79.1(2).

(4) Recalculation of base rates (rebasing).

1. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency, the base rates will be recalculated based on the reasonable and proper actual costs of operation as calculated by the fiscal year 2022 financial and statistical report.

2. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency; and 15-minute HCBS intellectual disability waiver supported community living services, the base rates will be recalculated based on the reasonable and proper costs of operation for the provider's fiscal year ending on or after January 1, 2024.

3. Subsequent to the recalculation of base rates in numbered paragraph 79.1(15)*"d"*(4)"2," a provider's base rate will be recalculated no less than every three years.

(5) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

e. Reserved.

f. Retrospective adjustments.

(1) For fee for service, retrospective adjustments will be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for 15-minute HCBS intellectual disability waiver supported community living services; HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency under an HCBS intellectual disability waiver, brain injury waiver, and health and disability waiver, as reported on the applicable department form, subject to the upper rate limit allowed in subrule 79.1(2).

(2) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent for fee for service will be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) If a provider does not remit the amount of the overpayment identified in subparagraph 79.1(15)*"f"*(2) within 30 days after notice, the department will deduct the amount owed from future payments.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to July 1, 2026, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2024, means the hospital's cost report with fiscal year end on or after January 1, 2022, and before January 1, 2023. Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" means the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in determining the statewide base APC rate.

"Cost outlier" means services provided during a single visit that have an extraordinarily high cost as established in paragraph 79.1(16)*"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" or *"CPT"* is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly. For the purposes of this rule, "CPT" means the coding as amended to July 1, 2026.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports in determining the direct medical education rate.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the factor used to limit aggregate expenditures to available funding and then divided by the sum of outpatient relative discounted APC weights.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report. The claim set is updated every three years in July and is modeled using recalibrated weights pursuant to paragraph 79.1(5)*"r."*

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the CPT and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2019, through December 31, 2020, and paid through March 31, 2020.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 as amended to July 1, 2026, and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 as amended to July 1, 2026.

"Outpatient visit" means those hospital-based outpatient services that are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Rebasing" means the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" means the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to July 1, 2026, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services (CMS) to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to July 1, 2026, is eligible for combined billing status if the hospital has filed the approval notice with Iowa Medicaid. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services will be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services will be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight will be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs will be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Separately payable clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Separately payable nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E1	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
E2	Items, codes, and services: ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."*

Indicator	Item, Code, or Service	OPPS Payment Status
		If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J1	Hospital Part B services paid through a comprehensive APC	If covered by Iowa Medicaid, the service is paid under OPPS APC. All covered Part B services on the claim, except services with OPPS SI=F, G, H, L, and U; ambulance services; diagnostic and screening mammography; and all preventive services. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J2	Hospital Part B services that may be paid through a comprehensive APC	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. ● In other circumstances, payment is made through a separate APC payment. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STV-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," or "V." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
		● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS APC. ● Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. ● In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS APC or Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* ● Packaged APC payment if billed on the same claim as HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." ● In other circumstances, laboratory tests should have a status indicator of "A" and payment is made under the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."*
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by

Indicator	Item, Code, or Service	OPPS Payment Status
		Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Reserved.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552.

(2) The cost-to-charge ratios are applied to each line-item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding and then divided by the hospital-specific sum of relative discounted APC weights in the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then divided by the sum of relative discounted APC weights in the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* will be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department will determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department will recover the difference.

(1) After any retrospective adjustment, the department will update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department will base these changes on the most recent utilization as submitted to the Iowa Medicaid and Medicare cost principles. Providers may be eligible for an "add-on" to the cost-to-charge ratio based on eligibility to participate in the annual Critical Access Hospital Cost Adjustment Factor Pool.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15 as amended to July 1, 2026, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552, Hospitals and Healthcare Complex Cost Report);

2. Either the Critical Access Hospital Supplemental Cost Report or the Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to Iowa Medicaid at the department's address.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department will update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates will be rebased. Cost reports used in rebasing will be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission timelines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code

crosswalk, to Iowa Medicaid by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices will be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund will be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program will be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs 79.1(16)*"k"*(1) and *"k"*(2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly and are available from the department.

(1) The hospital shall provide the Iowa Medicaid authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid, pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be implemented until federal financial participation to match money collected from the health care access assessment, pursuant to 441—Chapter 36, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when

a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement will be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Reserved.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room will be made pursuant to a fee schedule. Payment for treatment of a Medicaid member in an emergency room will be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room will be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the APC methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 and 447.325, both as amended to July 1, 2026. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Reserved.

u. Iowa Medicaid review. The department will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals.

v. Graduate medical education and disproportionate share fund. Payment will be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under

the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the sum of updated OPPS relative discounted APC weights, pursuant to paragraph 79.1(16)*"j,"* for the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to Iowa Medicaid for prior approval before the modification is initiated or the equipment is purchased. Payment will not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable will be based on the least expensive item that meets the member's medical needs.

c. Payment for most items will be based on a fee schedule and will conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee will be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee will be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m as amended to July 1, 2026), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee will be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price will be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price will be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment will be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment will not exceed 80 percent of the purchase allowance.

(8) No allowance will be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management (PCM) services reimbursement.* Pharmacist and PCM team members will be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member will be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments will be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventive follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services will be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services will be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee will be established for translation and interpretation services, which will be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026.

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in subrule 79.1(2), payments to rehabilitation agencies will be made as provided in the areawide fee schedule established for Medicare by the CMS as amended to July 1, 2026. The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association as amended to July 1, 2026. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims.* Subject to approval of a state plan amendment by CMS, payment for Medicare crossover claims will be made as follows.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicaid-allowed amount" means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicare-allowed amount" means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare cost sharing" means the Medicare member's responsibility to pay for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Medicare crossover claim" means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicare deductible and coinsurance amounts" means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare provider reimbursement" means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

"Third-party payment" means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims will be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) and **79.1(24)** Reserved.

79.1(25) *Reimbursement for community mental health centers (CMHCs).* CMHCs may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department. Once a CMHC chooses the alternative reimbursement rate methodology, the CMHC may not change its elected reimbursement methodology to 100 percent of reasonable costs.

a. Cost-based reimbursement. For CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following:

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, Iowa Medicaid will make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or

2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, Iowa Medicaid will make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that Iowa Medicaid will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by Iowa Medicaid. Iowa Medicaid will determine each provider's actual, allowable costs in accordance with generally accepted accounting

principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) Iowa Medicaid will make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) Iowa Medicaid will use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using a Financial and Statistical Report form. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552. The following requirements apply to all required cost reports:

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to July 1, 2026.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to Iowa Medicaid at the department's address. A provider that is not hospital-based shall submit a Financial and Statistical Report form on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both a Financial and Statistical Report form and CMS Form 2552 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to Iowa Medicaid. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, Iowa Medicaid will reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate will be paid for not longer than three months, after which time no further payments will be made.

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. Rate determination based on cost reports. Reimbursement will be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers will be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and Iowa Medicaid may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed will be subject to review or audit or both by Iowa Medicaid to determine the actual cost of services in accordance with generally accepted accounting principles, and Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, both as amended to July 1, 2026, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment will be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. Financial and statistical report submission and reporting requirements.

(1) The provider shall submit the complete Financial and Statistical Report form in an electronic format approved by the department to Iowa Medicaid within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to Iowa Medicaid. The extension request must be received by Iowa Medicaid before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to Iowa Medicaid in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to the email address on the form on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to Iowa Medicaid at the department's address no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)*"b"*(4), the department will reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) will be effective the first day of the sixth month following the provider's fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by Iowa Medicaid.

2. The reduced rate(s) will be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by Iowa Medicaid.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates will be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items that had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify Iowa Medicaid when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27)*"b."*

(2) For facilities that terminate activity with Iowa Medicaid, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless of if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27)*"a"* shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, Iowa Medicaid will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled will be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate will be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers will be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan starts to pay.

"Eligible member" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"Health insurance premium payment (HIPP) program" or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use a Health Insurance Premium Payment (HIPP) Provider Invoice form.

(1) Payment will be made to eligible providers for a HIPP program-eligible member's coinsurance, copayment, and deductible when the HIPP program-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1)*"c"* provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment as amended to July 1, 2026. The SIS assessment tool and scoring criteria are available on request from Iowa Medicaid.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30)*"f"* and *"g,"* are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30)*"g,"* acuity tiers are the highest applicable tier pursuant to the following:

(1) Tier 1: SIS activities score of 0 – 25.

(2) Tier 2: SIS activities score of 26 – 40.

(3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.

(4) Tier 4: SIS activities score of 45 or higher.

(5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.

(6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.

(7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.

(8) RBSCL tier: Members residing in a residential-based supported community living (RBSCL) facility.

(9) Enhanced tier: An individual member rate negotiated between the department and the provider.

g. The tier determined pursuant to paragraph 79.1(30)*"f"* shall be adjusted as follows:

(1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)*"e"*(1), but with a response of "extensive support needed" (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)*"e"*(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by two tiers.

(4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.

h. Tier redetermination. A member's acuity tier may be changed in the following circumstances:

(1) There is a change in the member's SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).

(2) A completed Emergency Needs Assessment form indicates a change in the member's support needs. A member's case manager may request an emergency needs assessment when a significant change in the member's needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member's acuity tier.

i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers, or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)*"c."*

441—79.2(249A) Sanctions.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

"Iowa Medicaid" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity that is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) *Grounds for sanctions.* The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include but are not limited to the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections, appeals, and licensing's Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act that is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or

accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.*

a. The department may impose any of the following sanctions on any person:

(1) A term of probation for participation in the medical assistance program.

(2) Termination from participation in the medical assistance program.

(3) Suspension from participation in the medical assistance program.

(4) Suspension of payments in whole or in part.

(5) Prior authorization of services.

(6) Review of claims prior to payment.

b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program will be retroactive to the date established by the CMS or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the department of justice, the department of inspections, appeals, and licensing, or a similar agency that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department will immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension will end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department will consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include but are not limited to:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of provider education (technical assistance).

f. Provider willingness to obey program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR §1002.212 as amended to July 1, 2026, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members as provided in 42 CFR §1001.2005 and 1001.2006, both as amended to July 1, 2026, whenever the department initiates an exclusion under 42 CFR §1002.210 as amended to July 1, 2026.

79.2(7) *Notice of violation.*

a. Any order of sanction will be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction will also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction will remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the department. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it will notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with Iowa Code section 249A.11 or 249A.47 are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance will the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under Iowa Code section 249A.39 must be made in writing, addressed to Iowa Medicaid, and contain all of the following:

(1) Person's name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) Claim number(s), as appropriate.

(6) Date(s) of service.

(7) Member identification number(s).

(8) National provider identification (NPI) number.

(9) Description of the corrective action plan to ensure the error does not occur again, if applicable.

(10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.

(11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Unless otherwise indicated below, the provider may document the services in any format so long as the documentation adequately substantiates the medical necessity and that the services were rendered. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"d,"* 441—paragraph 77.39(14)*"d,"* 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).

5. Medication administration record (MAR). The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service.

7. Narrative description of any incidents or illnesses or unusual or atypical occurrences that occur during service provision.

8. Any supplies dispensed as part of the service.

9. The first and last name and professional credentials, if any, of the person providing the service.

10. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

11. For 24-hour care, documentation for every shift of the services provided.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it).

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Other service documentation as applicable.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.
3. Other service documentation as applicable.

(9) Clinic services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.
2. Prenatal Risk Assessment form.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
7. Other service documentation as applicable.

(12) Screening center services:

1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Prenatal Risk Assessment form.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Prenatal Risk Assessment form.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, or discharge summary).
2. Physician orders.

3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, or discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Case Activity Report form.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Case Activity Report form.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Resident Care Agreement form.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Case Activity Report form.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Case Activity Report form.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Election of Medicaid Hospice Benefit form.

3. Revocation of Medicaid Hospice Benefit form.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:
1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.
4. Other service documentation as applicable.

(25) Behavioral health intervention:
1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.
4. Other service documentation as applicable.

(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician, nurse practitioner, physician assistant, or clinical nurse specialist orders or medical orders.

(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:
1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:
1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Notice of decision for service authorization.
2. Service notes or narratives.
3. Social history.
4. Comprehensive service plan.
5. Reassessment of member needs.
6. Incident reports in accordance with 441—subrule 24.4(5).
7. Other service documentation as applicable.

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. HCBS Attendant Care Agreement and Attendant Care Service Record.
8. Other service documentation as applicable.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing form.
2. Waiver of informed consent.
3. Prior authorization documentation.
4. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.
4. Other service documentation as applicable.

(40) Reserved.

(41) Services of public health agencies:

1. Service or office notes or narratives.
2. Immunization records.
3. Results of communicable disease testing.

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:

1. Department-approved standardized neurobehavioral assessment tool.
2. Community-based neurobehavioral treatment order.
3. Treatment plan.

4. Clinical records documenting diagnosis and treatment history.
5. Progress or status notes.
6. Service notes or narratives.
7. Procedure, laboratory, or test orders and results.
8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
9. Medication administration records.
10. Other service documentation as applicable.

(43) Child care medical services:

1. Plan of care.
2. Certification and recertification.
3. Service notes or narratives.
4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or Iowa Medicaid that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by Iowa Medicaid will include a Documentation Checklist form, which is available on the department's website, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, "good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit is considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size will be selected using accepted sample size estimation methods. The confidence level of the sample size calculation will not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by Iowa Medicaid, the request should be addressed to Iowa Medicaid at the department's address.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to the department at its address.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph 79.4(5)*"a"* may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department will issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal will not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) are not admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and federal regulations 45 CFR Part 84, both as amended to July 1, 2026, which prohibit discrimination on the basis of handicap in all federal Department of Health and Human Services funded programs.

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on an Agreement Between Provider of Medical and Health Services and the Iowa Department of Health and Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete an Addendum to Dental Provider Agreement for Orthodontia to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.*

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by the department. The initial ballot will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with department staff and the director, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership.* The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department.

(1) The length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2)*"a"*(3).

b. Council membership of public representatives shall consist of five representatives, of whom one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. Reserved.

d. Council membership shall also consist of state agency and medical school partners, including representatives from Des Moines University Medicine and Health Sciences and the University of Iowa Carver College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) 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.

(2) 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 from their respective parties.

79.7(3) *Responsibilities, duties and meetings.* The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department.

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department or the professional and business entities represented. The director will consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department. The department will arrange for a meeting place, related services, and accommodations. The department will provide staff support and independent technical assistance to the council.

a. The department will provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department will present the annual budget for the medical assistance program for review and comment.

c. The department will permit staff members to appear before the council to review and discuss specific information and problems.

d. The department will maintain a current list of members on the council.

e. The department will be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through an MCO. For services provided through an MCO, the prior authorization request is submitted, reviewed, and authorized by the MCO.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using an Outpatient Prior Authorization Request form, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to Iowa Medicaid. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use a Prior Authorization Attachment Control form as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on that form the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial of prescription drugs will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d) as amended to July 1, 2026.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services will be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval will be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive covered procedures that would be as effective.

(5) The advice of an appropriate professional consultant.

b. When Iowa Medicaid has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) Iowa Medicaid will issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. Iowa Medicaid will mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by Iowa Medicaid, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service that would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)*"b,"* medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)*"a,"* medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by Iowa Medicaid as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact Iowa Medicaid to request approval of Medicaid coverage for the hospitalization according to instructions issued to providers by Iowa Medicaid and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if Iowa Medicaid denies the procedure requested in the preadmission review.

79.10(3) Iowa Medicaid will issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of

the decision by filing a written request with Iowa Medicaid within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

441—79.11(249A) Requests for preprocedure surgical review. Iowa Medicaid conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from Iowa Medicaid when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by Iowa Medicaid.

79.11(2) Iowa Medicaid will issue the physician a validation number for each request and advise whether payment for the procedure will be approved or denied.

79.11(3) Iowa Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, e.g., hospital or ambulatory surgical center, if Iowa Medicaid does not give approval.

79.11(4) Iowa Medicaid will issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with Iowa Medicaid within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid in accordance with 441—Chapter 7.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and an HMO at the time of enrollment of the person with the organization shall provide written information to each adult that explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law that allows for an objection on the basis of conscience for any provider or organization that as a matter of conscience cannot implement an advance directive.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid-enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Public Law 100-578, both as amended to July 1, 2026, and implementing federal regulations published at 42 CFR Part 493 as amended to July 1, 2026. Medicaid payment will not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with an MCO, shall begin the enrollment process by completing the appropriate application on the department's website. Managed care organizations and fiscal agents are exempt from completing an application.

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

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

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

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

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

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

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

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to Iowa Medicaid at the department's address.

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

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

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

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

c. Reserved.

d. Application fees.

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

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

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

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

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

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

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

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

1. Individual physicians or nonphysician practitioners.

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

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

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR §455.460 as amended to July 1, 2026.

79.14(3) Program integrity information requirements.

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

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)*"a"*(1), *"a"*(2), *"a"*(3), *"a"*(4), or *"a"*(5).

b. Iowa Medicaid may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7, but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. Iowa Medicaid will deny enrollment to or immediately disenroll any person that Iowa Medicaid, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and will deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)*"c."* Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

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

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

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

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the "limited," "moderate," or "high" categorical risk screening procedures and requirements in accordance with 42 CFR §455.450 as amended to July 1, 2026.

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

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

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

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

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

79.14(5) Notification. A provider will be notified of the decision on the provider's application within 30 calendar days of receipt by Iowa Medicaid of a complete and correct application with all required documents, including but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by Iowa Medicaid.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment will be made to a provider for care or services provided prior to the effective date of Iowa Medicaid's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided will be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to Iowa Medicaid and will be approved or denied within 30 calendar days. Approval of an amendment will be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by Iowa Medicaid. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform Iowa Medicaid of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include but are not limited to changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, Iowa Medicaid may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

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

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

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. Iowa Medicaid must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416 as amended to July 1, 2026.

79.14(15) Temporary moratoria. Iowa Medicaid must impose any temporary moratorium pursuant to Iowa Code section 249A.48.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed Iowa Medicaid while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, that provide detailed information about:

(1) The False Claims Act established under 31 U.S.C. Sections 3729 through 3733 as amended to July 1, 2026;

(2) Administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38 as amended to July 1, 2026;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs 79.15(1)*"a"*(1) through *"a"*(3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs as defined in 42 U.S.C. Section 1320a-7b(f) as amended to July 1, 2026; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to Iowa Medicaid by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to Iowa Medicaid at the department's address; or

(2) Faxing the information to 515.725.1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032, as amended to July 1, 2026.

441—79.16 Reserved.

441—79.17(249A) Requirements for prescribing controlled substances.

79.17(1) *Review of Iowa prescription monitoring program database.* A prescribing practitioner, as defined in Iowa Code section 124.550, or the prescribing practitioner's designated agent, shall review patient information in the Iowa prescription monitoring program (PMP) database prior to issuing a prescription for a controlled substance as defined in 42 U.S.C. 1396w–3a, inclusive of Schedules II, III and IV as amended to July 1, 2026, unless the patient is receiving inpatient hospice care or long-term residential facility care. Review shall be conducted in accordance with all requirements under the prescribing practitioner's specific professional licensing authority.

79.17(2) *Documentation.* The prescribing practitioner shall include documentation in the patient file to demonstrate compliance with subrule 79.17(1). Subject to the requirements under Iowa Code chapter 124, subchapter VI, if the prescribing practitioner is not able to conduct a review of the PMP database despite a good-faith effort, the prescribing practitioner must document in the patient file such good-faith effort, including the reasons why the prescribing practitioner was not able to conduct the review. The prescribing practitioner shall submit such documentation to Iowa Medicaid upon request.

This rule is intended to implement Iowa Code chapters 124 and 249A.

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