



IOWA ADMINISTRATIVE BULLETIN

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Pages 3173 to 3871

CONTENTS IN THIS ISSUE

Pages 3787 to 3870 include **ARC 8245C** to **ARC 8260C**

ADVISORY NOTICE

Transition of document processing
software for rule publications 3871

ALL AGENCIES

Agency identification numbers 3188
Citation of administrative rules 3177
Schedule for rulemaking 3178

ECONOMIC DEVELOPMENT AUTHORITY[261]

Filed, STEM BEST appropriation;
division responsibilities; Iowa
targeted small business procurement
program; mission and responsibilities;
Iowa innovation council,
rescind chs 15, 21, 50, 54, 101, 114,
163 **ARC 8258C** 3848
Filed, Iowa targeted small business
certification program, ch 52 **ARC 8259C** . . . 3849
Filed, Targeted small business financial
assistance program, ch 55 **ARC 8260C** 3854

EDUCATION DEPARTMENT[281]

Regulatory Analysis, Administration—
library programs, compliance with
Iowa Code section 279.80, 12.3 3190
Regulatory Analysis, Dual enrollment, 31.5(4) . 3193

HUMAN RIGHTS DEPARTMENT[421]

Regulatory Analysis, Functions of
division, rescind ch 40. 3195
Regulatory Analysis, Hall of fame,
rescind ch 41 3197

HUMAN SERVICES DEPARTMENT[441]

Regulatory Analysis, Facility assessments,
ch 36 3199
Regulatory Analysis, Application for aid,
ch 40 3204
Regulatory Analysis, Granting assistance,
ch 41 3214
Regulatory Analysis, Alternate payees,
rescind ch 43 3255
Regulatory Analysis, Payment, ch 45 3257
Regulatory Analysis, Overpayment
recovery, ch 46 3261
Regulatory Analysis, Diversion initiatives,
ch 47 3266
Regulatory Analysis, Family
development and self-sufficiency
(FaDSS) program, ch 49 3271
Regulatory Analysis, Application for
assistance, ch 50 3276
Regulatory Analysis, Eligibility, ch 51 3280
Regulatory Analysis, Payment, ch 52 3285
Regulatory Analysis, Facility
participation, ch 54 3289
Regulatory Analysis, Interim assistance
reimbursement, ch 57 3293
Regulatory Analysis, Refugee cash
assistance, ch 60 3296
Regulatory Analysis, Refugee services
program, ch 61 3305
Regulatory Analysis, Rent reimbursement,
ch 62 3313

Regulatory Analysis, Supplemental nutrition assistance program administration, ch 65	3318	Regulatory Analysis, Standards of practice and principles of medical ethics, ch 13	3459
Regulatory Analysis, Emergency food assistance program, ch 66	3323	Regulatory Analysis, Licensure of acupuncturists, ch 17	3484
Regulatory Analysis, Special supplemental nutrition program for women, infants, and children (WIC), ch 67 . .	3326	Regulatory Analysis, Prescribing psychologists, ch 19	3494
Regulatory Analysis, Ambulance service, 78.11	3335	Regulatory Analysis, Licensure of genetic counselors, ch 20	3504
Regulatory Analysis, Nursing facilities, ch 81 . .	3596	Regulatory Analysis, Physician supervision of a physician assistant, ch 21 . . .	3512
Regulatory Analysis, Intermediate care facilities for persons with an intellectual disability, ch 82	3337	Regulatory Analysis, Mandatory reporting, ch 22	3518
Regulatory Analysis, Family planning program, ch 87	3356	Regulatory Analysis, Grounds for discipline, ch 23	3522
Regulatory Analysis, Child care centers, ch 109	3368	Regulatory Analysis, Complaints and investigations, ch 24	3530
Regulatory Analysis, Early childhood Iowa initiative, ch 121	3390	Regulatory Analysis, Reinstatement after disciplinary action, ch 26	3539
Regulatory Analysis, Monthly foster family home payment; kinship caregiver payment, 156.6(1), 156.7	3394		
LABOR SERVICES DIVISION[875]		PUBLIC HEALTH DEPARTMENT[641]	
WORKFORCE DEVELOPMENT DEPARTMENT[871]“umbrella”		Regulatory Analysis, Maternal deaths, rescind ch 5	3543
Notice, Consultative services, ch 8 ARC 8253C	3787	Regulatory Analysis, Approval of confirmatory laboratories for private sector drug-free workplace testing, ch 12	3545
Notice, OSHA discrimination against employees, ch 9 ARC 8254C	3794	Regulatory Analysis, Community water fluoridation grant program, rescind ch 20	3553
Notice, Sanitation and shelter rules for railroad employees, ch 29 ARC 8255C	3797	Regulatory Analysis, Oral health, rescind ch 50	3555
		Regulatory Analysis, Dental screening, ch 51	3557
MEDICINE BOARD[653]		Regulatory Analysis, Vision screening, ch 52	3563
PUBLIC HEALTH DEPARTMENT[641]“umbrella”		Regulatory Analysis, Brain injury advisory council, rescind ch 55	3569
Regulatory Analysis, Administrative and regulatory authority, ch 1	3397	Regulatory Analysis, Blood lead testing, ch 67 .	3571
Regulatory Analysis, Public records and fair information practices; waivers; nonpayment of state debt; Iowa physician health committee—Iowa physician health program; child support noncompliance; military service and veteran reciprocity; contested case proceedings, rescind chs 2, 3, 12, 14, 15, 18, 25	3402	Regulatory Analysis, Control of lead-based paint hazards, ch 68	3574
Regulatory Analysis, Fees, ch 8	3405	Regulatory Analysis, Emergency information system on pesticides for use by health care providers during medical emergencies, rescind ch 71	3580
Regulatory Analysis, Permanent and administrative medicine physician licensure, ch 9	3411	Regulatory Analysis, Childhood lead poisoning prevention program, ch 72	3582
Regulatory Analysis, Resident, special and temporary physician licensure, ch 10	3432	Regulatory Analysis, Family planning services, rescind ch 74	3585
Regulatory Analysis, Continuing education and training requirements, ch 11 . .	3451	Regulatory Analysis, Distribution of federal funds restrictions—provider identification and attestation, ch 75	3587

Regulatory Analysis, Maternal and child health program, ch 76	3590
Regulatory Analysis, Personal responsibility education program and Title V state sexual risk avoidance education grant program funding and restrictions, rescind ch 78	3594
Regulatory Analysis, Healthy families Iowa (HFI), rescind ch 87	3652
Regulatory Analysis, Parental notification of intent to terminate a pregnancy through abortion, ch 89	3654
Regulatory Analysis, Iowa domestic abuse death review team, rescind ch 91	3657
Regulatory Analysis, Iowa fatality review committee, rescind ch 92	3659
Regulatory Analysis, Child protection center grant program, rescind ch 94	3661
Regulatory Analysis, Public health response teams, ch 113	3663
Regulatory Analysis, Preparedness advisory council, rescind ch 114	3668
Regulatory Analysis, Anatomical gift public awareness and transplantation fund, rescind ch 122	3670
Regulatory Analysis, Interagency coordinating council for the state medical examiner, rescind ch 124	3672
Regulatory Analysis, Emergency medical services advisory council, rescind ch 130	3674
Regulatory Analysis, Emergency medical services—providers—initial certification—renewal and reactivation—authority—complaints and investigations, ch 131	3676
Regulatory Analysis, Emergency medical services—service program authorization, ch 132	3691
Regulatory Analysis, White flashing light authorization, ch 133	3706
Regulatory Analysis, Trauma care facility categorization and verification, ch 134	3710
Regulatory Analysis, Trauma triage and transfer protocols, ch 135	3715
Regulatory Analysis, Trauma registry, ch 136 ..	3718
Regulatory Analysis, Trauma education and training, ch 137	3721
Regulatory Analysis, Trauma system advisory council, rescind ch 138	3725

Regulatory Analysis, Emergency medical services—training programs —students—complaints and investigations, ch 139	3727
Regulatory Analysis, Emergency medical services system development grants fund, ch 140	3735
Regulatory Analysis, Out-of-hospital do-not-resuscitate orders, ch 142	3739
Regulatory Analysis, Automated external defibrillator maintenance, ch 143 ...	3749
Regulatory Analysis, Emergency medical services—air medical service program authorization, rescind ch 144	3752
Regulatory Analysis, Iowa regionalized system of perinatal health care, ch 150	3754
Regulatory Analysis, Standards for substance abuse treatment and assessment and the operating a motor vehicle while intoxicated (OWI) law, ch 157	3770
Regulatory Analysis, Regions for substance abuse prevention and treatment, rescind ch 158	3775

PUBLIC HEARINGS

Summarized list.	3179

RACING AND GAMING COMMISSION[491]

Regulatory Analysis, Sports wagering; fantasy sports contests, 13.2, 13.5, 13.6(3), 14.7(2), 14.8(1)	3777

TRANSPORTATION DEPARTMENT[761]

Regulatory Analysis, Automated traffic enforcement mobile systems, ch 145	3783
Notice, Contested cases, ch 13 ARC 8245C ...	3805
Notice, Holiday rest stops, ch 105 ARC 8246C .	3809
Notice, Real property acquisition and relocation assistance, ch 111 ARC 8250C ...	3812
Notice, Primary highway access control, ch 112 ARC 8251C	3814
Notice, Junkyard control, ch 116 ARC 8247C ..	3825
Notice, Outdoor advertising, ch 117 ARC 8248C	3829
Notice, Logo signing, ch 118 ARC 8249C	3836
Notice, Tourist-oriented directional signing, ch 119 ARC 8252C	3843

UTILITIES COMMISSION[199]

Filed, Electronic filing, ch 14 ARC 8256C	3857

Filed, Crossing of railroad rights-of- way, ch 42 ARC 8257C	3863

PREFACE

The Iowa Administrative Bulletin is published biweekly pursuant to Iowa Code chapters 2B and 17A and contains Notices of Intended Action and rules adopted by state agencies.

It also contains Proclamations and Executive Orders of the Governor which are general and permanent in nature; Regulatory Analyses; effective date delays and objections filed by the Administrative Rules Review Committee; Agenda for monthly Administrative Rules Review Committee meetings; and other materials deemed fitting and proper by the Administrative Rules Review Committee.

The Bulletin may also contain public funds interest rates [12C.6]; usury rates [535.2(3)“a”]; agricultural credit corporation maximum loan rates [535.12]; and other items required by statute to be published in the Bulletin.

PLEASE NOTE: Underscore indicates new material added to existing rules; ~~strike through~~ indicates deleted material.

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CITATION of Administrative Rules

The Iowa Administrative Code shall be cited as (agency identification number) IAC (chapter, rule, subrule, paragraph, subparagraph, or numbered paragraph).

This citation format applies only to external citations to the Iowa Administrative Code or Iowa Administrative Bulletin and does not apply to citations within the Iowa Administrative Code or Iowa Administrative Bulletin.

441 IAC 79	(Chapter)
441 IAC 79.1	(Rule)
441 IAC 79.1(1)	(Subrule)
441 IAC 79.1(1)“a”	(Paragraph)
441 IAC 79.1(1)“a”(1)	(Subparagraph)
441 IAC 79.1(1)“a”(1)“1”	(Numbered paragraph)

The Iowa Administrative Bulletin shall be cited as IAB (volume), (number), (publication date), (page number), (ARC number).

IAB Vol. XII, No. 23 (5/16/90) p. 2050, ARC 872A

Note: In accordance with Iowa Code section 2B.5A, a rule number within the Iowa Administrative Code includes a reference to the statute which the rule is intended to implement: 441—79.1(249A).

Schedule for Rulemaking 2024

NOTICE† SUBMISSION DEADLINE	NOTICE PUB. DATE	HEARING OR COMMENTS 20 DAYS	FIRST POSSIBLE ADOPTION DATE 35 DAYS	ADOPTED FILING DEADLINE	ADOPTED PUB. DATE	FIRST POSSIBLE EFFECTIVE DATE	POSSIBLE EXPIRATION OF NOTICE 180 DAYS
Jan. 3 '24	Jan. 24 '24	Feb. 13 '24	Feb. 28 '24	Mar. 1 '24	Mar. 20 '24	April 24 '24	Jul. 22 '24
Jan. 19	Feb. 7	Feb. 27	Mar. 13	Mar. 15	April 3	May 8	Aug. 5
Feb. 2	Feb. 21	Mar. 12	Mar. 27	Mar. 29	April 17	May 22	Aug. 19
Feb. 16	Mar. 6	Mar. 26	April 10	April 12	May 1	June 5	Sep. 2
Mar. 1	Mar. 20	April 9	April 24	April 26	May 15	June 19	Sep. 16
Mar. 15	April 3	April 23	May 8	**May 8**	May 29	Jul. 3	Sep. 30
Mar. 29	April 17	May 7	May 22	May 24	June 12	Jul. 17	Oct. 14
April 12	May 1	May 21	June 5	June 7	June 26	Jul. 31	Oct. 28
April 26	May 15	June 4	June 19	**June 19**	Jul. 10	Aug. 14	Nov. 11
May 8	May 29	June 18	Jul. 3	Jul. 5	Jul. 24	Aug. 28	Nov. 25
May 24	June 12	Jul. 2	Jul. 17	Jul. 19	Aug. 7	Sep. 11	Dec. 9
June 7	June 26	Jul. 16	Jul. 31	Aug. 2	Aug. 21	Sep. 25	Dec. 23
June 19	Jul. 10	Jul. 30	Aug. 14	**Aug. 14**	Sep. 4	Oct. 9	Jan. 6 '25
Jul. 5	Jul. 24	Aug. 13	Aug. 28	Aug. 30	Sep. 18	Oct. 23	Jan. 20 '25
Jul. 19	Aug. 7	Aug. 27	Sep. 11	Sep. 13	Oct. 2	Nov. 6	Feb. 3 '25
Aug. 2	Aug. 21	Sep. 10	Sep. 25	Sep. 27	Oct. 16	Nov. 20	Feb. 17 '25
Aug. 14	Sep. 4	Sep. 24	Oct. 9	Oct. 11	Oct. 30	Dec. 4	Mar. 3 '25
Aug. 30	Sep. 18	Oct. 8	Oct. 23	**Oct. 23**	Nov. 13	Dec. 18	Mar. 17 '25
Sep. 13	Oct. 2	Oct. 22	Nov. 6	**Nov. 6**	Nov. 27	Jan. 1 '25	Mar. 31 '25
Sep. 27	Oct. 16	Nov. 5	Nov. 20	**Nov. 20**	Dec. 11	Jan. 15 '25	April 14 '25
Oct. 11	Oct. 30	Nov. 19	Dec. 4	**Dec. 4**	Dec. 25	Jan. 29 '25	April 28 '25
Oct. 23	Nov. 13	Dec. 3	Dec. 18	**Dec. 18**	Jan. 8 '25	Feb. 12 '25	May 12 '25
Nov. 6	Nov. 27	Dec. 17	Jan. 1 '25	**Jan. 2 '25**	Jan. 22 '25	Feb. 26 '25	May 26 '25
Nov. 20	Dec. 11	Dec. 31	Jan. 15 '25	Jan. 17 '25	Feb. 5 '25	Mar. 12 '25	June 9 '25
Dec. 4	Dec. 25	Jan. 14 '25	Jan. 29 '25	Jan. 31 '25	Feb. 19 '25	Mar. 26 '25	June 23 '25
Dec. 18	Jan. 8 '25	Jan. 28 '25	Feb. 12 '25	Feb. 14 '25	Mar. 5 '25	April 9 '25	Jul. 7 '25
Dec. 20 '23	Jan. 10	Jan. 30	Feb. 14	Feb. 16	Mar. 6	April 10	Jul. 8

PRINTING SCHEDULE FOR IAB

<u>ISSUE NUMBER</u>	<u>SUBMISSION DEADLINE</u>	<u>ISSUE DATE</u>
10	Wednesday, October 23, 2024	November 13, 2024
11	Wednesday, November 6, 2024	November 27, 2024
12	Wednesday, November 20, 2024	December 11, 2024

PLEASE NOTE:

Rules will not be accepted by the Publications Editing Office after **12 o'clock noon** on the filing deadline unless prior approval has been received from the Administrative Rules Coordinator and the Administrative Code Editor.

If the filing deadline falls on a legal holiday, submissions made on the following Monday will be accepted.

†To allow time for review by the Administrative Rules Coordinator prior to the Notice submission deadline, Notices should generally be submitted in RMS four or more working days in advance of the deadline.

****Note change of filing deadline****

ADMINISTRATIVE SERVICES DEPARTMENT[11]

Organization and operation; state library of Iowa, 1.4(7), 111.2(12), ch 130; programs and funding, ch 131; Internet use policy, ch 132
IAB 10/2/24
Regulatory Analysis

Room 310—Library Conference Room
Ola Babcock Miller Building
Des Moines, Iowa

October 24, 2024
1 to 2 p.m.

CREDIT UNION DIVISION[189]

Credit union review board—meeting frequency, 1.3(2); board of directors—meeting frequency, 2.9(1)
IAB 10/2/24
Regulatory Analysis

Video call link:
meet.google.com/brb-hssd-qnj
Join by phone: 1.813.773.5922
PIN: 808 235 241#

October 22, 2024
2 to 2:30 p.m.

DENTAL BOARD[650]

Agency realignment; rescind chs 1, 6, 10 to 16, 20 to 23, 25 to 27, 29 to 33, 35, 36, 50 to 52
IAB 10/2/24
Regulatory Analyses

6200 Park Avenue, Suite 100
Des Moines, Iowa
Via videoconference call:
meet.google.com/nuk-xcby-nyf
Or dial: 541.838.0234
PIN: 917 400 078#

October 22, 2024
12 noon

ECONOMIC DEVELOPMENT AUTHORITY[261]

Public records and fair information practices, ch 195
IAB 10/2/24
Regulatory Analysis

1963 Bell Avenue
Des Moines, Iowa
Registration information for online participation may be found at
www.iowaeda.com/red-tape-review/

October 22, 2024
9 to 9:15 a.m.

Petition for rulemaking, ch 197
IAB 10/2/24
Regulatory Analysis

1963 Bell Avenue
Des Moines, Iowa
Registration information for online participation may be found at
www.iowaeda.com/red-tape-review/

October 22, 2024
9:15 to 9:30 a.m.

Petition for declaratory order, ch 198
IAB 10/2/24
Regulatory Analysis

1963 Bell Avenue
Des Moines, Iowa
Registration information for online participation may be found at
www.iowaeda.com/red-tape-review/

October 22, 2024
9:30 to 9:45 a.m.

Waivers from administrative rules, ch 199
IAB 10/2/24
Regulatory Analysis

1963 Bell Avenue
Des Moines, Iowa
Registration information for online participation may be found at
www.iowaeda.com/red-tape-review/

October 22, 2024
9:45 to 10 a.m.

EDUCATION DEPARTMENT[281]

Administration—library programs, compliance with Iowa Code section 279.80, 12.3
IAB 10/16/24
Regulatory Analysis

Room B50
Grimes State Office Building
Des Moines, Iowa

November 5, 2024
8 to 9:30 a.m.

EDUCATION DEPARTMENT[281](cont'd)

Dual enrollment, 31.5(4)

IAB 10/16/24

Regulatory Analysis

Room B50

Grimes State Office Building

Des Moines, Iowa

November 5, 2024

8 to 9:30 a.m.

HUMAN RIGHTS DEPARTMENT[441]

Functions of division, rescind ch 40

IAB 10/16/24

Regulatory Analysis

Microsoft Teams

Meeting ID: 287 138 322 978

Passcode: w3jvk8

November 12, 2024

1 p.m.

Hall of fame, rescind ch 41

IAB 10/16/24

Regulatory Analysis

Microsoft Teams

Meeting ID: 287 138 322 978

Passcode: w3jvk8

November 12, 2024

1 to 2 p.m.

HUMAN SERVICES DEPARTMENT[421]

Facility assessments, ch 36; application
for aid, ch 40; ambulance service,
78.11; nursing facilities, ch 81;
intermediate care facilities for persons
with an intellectual disability, ch 82
IAB 10/16/24

Regulatory Analyses

Microsoft Teams

Meeting ID: 295 147 282 130

Passcode: jm6rgf

November 7, 2024

10 a.m.

Granting assistance, ch 41; payment,
ch 45; overpayment recovery, ch 46;
diversion initiatives, ch 47;
application for assistance, ch 50;
eligibility, ch 51; payment, ch 52;
facility participation, ch 54; interim
assistance reimbursement, ch 57;
refugee cash assistance, ch 60; refugee
services program, ch 61; rent
reimbursement, ch 62; SNAP, ch 65;
emergency food assistance program,
ch 66; WIC, ch 67; family planning
program, ch 87; child care centers, ch
109
IAB 10/16/24

Regulatory Analyses

Microsoft Teams

Meeting ID: 238 807 808 374

Passcode: sCAuM5

November 6, 2024

2 to 3 p.m.

Alternate payees, rescind ch 43

IAB 10/16/24

Regulatory Analyses

Microsoft Teams

Meeting ID: 233 331 347 558

Passcode: h2yRwX

November 7, 2024

2 p.m.

Family development and self-
sufficiency (FaDSS) program, ch 49;
Early childhood Iowa initiative, ch
121; monthly foster family home
payment; kinship caregiver payment,
156.6(1), 156.7
IAB 10/16/24

Microsoft Teams

Meeting ID: 287 138 322 978

Passcode: w3jvk8

November 12, 2024

1 to 2 p.m.

INSPECTIONS AND APPEALS DEPARTMENT[481]

Dental board administration, ch 570;
dental board fees, ch 571; dental
licensure, registration, renewal and
reinstatement, ch 572; dental
continuing education, ch 573; general
requirements and standards of
practice, ch 574; dental assistants,
dental radiography qualifications, and
dental laboratory technicians, ch 575
IAB 10/2/24

Regulatory Analyses

6200 Park Avenue, Suite 100
Des Moines, Iowa
Via videoconference call:
meet.google.com/nuk-xcby-nyf
Or dial: 541.838.0234
PIN: 917 400 078#

October 22, 2024
12 noon

Behavioral health professionals
licensing, ch 880, rescind chs 885,
895; Continuing education for marital
and family therapists, mental health
counselors, social workers, and
psychologists, adopt ch 881, rescind
chs 886, 892, 896; discipline for
marital and family therapists, mental
health counselors, behavior analysts,
psychologists, and social workers,
adopt ch 882, rescind chs 887, 893,
898; prescribing psychologists, adopt
ch 883; rescind ch 889; practice of
social workers, psychologists,
marriage and family therapists, and
mental health counselors, adopt ch
884; rescind chs 888, 891, 897
IAB 10/2/24

Regulatory Analyses

6200 Park Avenue, Suite 100
Des Moines, Iowa
Via videoconference call:
meet.google.com/mku-itia-ciq
Or dial: 1.573.342.3106
PIN: 861 856 486#

October 22, 2024
9 to 9:30 a.m.

INTERIOR DESIGN EXAMINING BOARD[193G]

Description of organization, ch 1;
registration, ch 2; continuing
education, ch 3; grounds for
discipline, disciplinary investigations,
and disciplinary proceedings, ch 5;
disciplinary investigations, rescind ch
6; disciplinary proceedings, rescind ch
7
IAB 10/2/24

Regulatory Analyses

6200 Park Avenue
Des Moines, Iowa
[us02web.zoom.us/j/87157328415?](https://us02web.zoom.us/j/87157328415?pwd=MUJIuarfeYpA4aEog7FSkQfzHyXifN.1)
[pwd=MUJIuarfeYpA4aEog7FSkQfzHyXifN.1](https://us02web.zoom.us/j/87157328415?pwd=MUJIuarfeYpA4aEog7FSkQfzHyXifN.1)

October 22, 2024
3 p.m.

IOWA FINANCE AUTHORITY[265]

Multifamily housing, ch 3
IAB 10/2/24 **ARC 8232C**

Suite 200
1963 Bell Avenue
Des Moines, Iowa
Registration information for online
participation may be found at
www.iowafinance.com/red-tape-review/

October 22, 2024
10:15 to 10:30 a.m.

October 24, 2024
2:15 to 2:30 p.m.

IOWA FINANCE AUTHORITY[265](cont'd)

Low-income housing tax credits; senior living revolving loan program; Iowa aftercare services rent subsidy program; transitional housing revolving loan program; council on homelessness; public service shelter grant fund; Iowans helping Iowans housing assistance program, rescind chs 12, 20, 22, 23, 31, 36, 40 IAB 10/2/24 ARC 8233C	Suite 200 1963 Bell Avenue Des Moines, Iowa Registration information for online participation may be found at www.iowafinance.com/red-tape-review/	October 22, 2024 10:30 to 10:45 a.m. October 24, 2024 2:30 to 2:45 p.m.

Petition for declaratory order, ch 16 IAB 10/2/24 Regulatory Analysis	Suite 200 1963 Bell Avenue Des Moines, Iowa Registration information for online participation may be found at www.iowafinance.com/red-tape-review/	October 22, 2024 9:30 to 9:45 a.m.

Home- and community-based services rent subsidy program, ch 24 IAB 10/2/24 ARC 8231C	Suite 200 1963 Bell Avenue Des Moines, Iowa Registration information for online participation may be found at www.iowafinance.com/red-tape-review/	October 22, 2024 10 to 10:15 a.m. October 24, 2024 2 to 2:15 p.m.

LABOR SERVICES DIVISION[875]

Consultative services, ch 8; OSHA discrimination against employees, ch 9; general industry safety and health, ch 10; construction safety and health, ch 26; occupational safety and health standards for agriculture, ch 28; railroad employees—sanitation and shelter, ch 29 IAB 10/16/24 ARC 8253C, ARC 8254C, ARC 8255C IAB 10/2/24 ARC 8234C, ARC 8238C, ARC 8239C	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	November 5, 2024 8:30 to 9 a.m. November 6, 2024 8:30 to 9 a.m.

Amusement ride inspections, ch 61; safety rules for amusement rides, amusement devices, and concession booths, ch 62; safety rules for bungee jumps, ch 63 IAB 10/2/24 Regulatory Analyses	Geode Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 23, 2024 8:30 to 9 a.m.

LABOR SERVICES DIVISION[875](cont'd)

Elevator safety board—petitions for rule making, declaratory orders, public records and fair information practices, rescind chs 67, 68, 70; boiler and pressure vessel board—administrative and regulatory authority, waivers, petitions for rule making, declaratory orders, contested cases, public records and fair information practices, adopt chs 80, 81, 84; rescind chs 82, 83, 85 IAB 9/18/24 Regulatory Analyses	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 22, 2024 8:30 to 9 a.m.
Administration of the boiler and pressure vessel program, ch 90; general requirements for all objects, ch 91; power boilers, ch 92; miniature power boilers installed prior to September 20, 2006, ch 93; steam heating boilers, hot water heating boilers, and hot water supply boilers, ch 94; unfired steam pressure vessels, ch 96 IAB 9/18/24 Regulatory Analyses	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 22, 2024 9 to 9:30 a.m.
Construction contractor registration, ch 150; asbestos removal and encapsulation, ch 155 IAB 10/2/24 Regulatory Analyses	Geode Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 23, 2024 9 to 9:30 a.m.
General requirements for athletic commission events, ch 169; professional boxing, ch 173; mixed martial arts, ch 177 IAB 10/2/24 Regulatory Analyses	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 24, 2024 10 to 10:30 a.m.
Grant applications and awards, ch 171; professional wrestling, ch 172; elimination tournaments, ch 174; amateur boxing, rescind ch 175; professional kickboxing, ch 176 IAB 10/2/24 Regulatory Analyses	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 24, 2024 10:30 to 11 a.m.
Operations of advisory board, rescind ch 170 IAB 9/18/24 Regulatory Analysis	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa	October 24, 2024 10:30 to 11 a.m.

LIBRARIES AND INFORMATION SERVICES DIVISION[286]

Agency realignment, rescind chs 1 to 3,
6, 7, 10 to 12
IAB 10/2/24

Regulatory Analysis

Room 310—Library Conference Room
Ola Babcock Miller Building
Des Moines, Iowa

October 24, 2024
1 to 2 p.m.

PUBLIC HEALTH DEPARTMENT[641]

Labs for private sector drug-free
workplace testing, ch 12; dental
screening, ch 51; vision screening, ch
52; blood lead testing, ch 67; lead-
based paint hazards, ch 68; childhood
lead poisoning prevention, ch 72;
federal funds restrictions—provider
ID, attestation, ch 75; maternal and
child health, ch 76; Parental
notification of intent to terminate
pregnancy through abortion, ch 89
IAB 10/16/24

Regulatory Analyses

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

November 6, 2024
2 to 3 p.m.

Maternal deaths, community water
fluoridation; oral health; brain injury
advisory council; pesticides for use by
health care providers; family planning
services; education—personal
responsibility and Title V state sexual
risk avoidance; healthy families Iowa;
domestic abuse death review team;
fatality review committee; child
protection center; preparedness
advisory council; anatomical gift
public awareness and transplantation
fund; EMS advisory council; trauma
system advisory council; EMS—air
medical service; substance abuse
prevention and treatment, rescind chs
5, 20, 50, 55, 71, 74, 78, 87, 91, 92,
94, 114, 122, 138, 144, 158
IAB 10/16/24

Regulatory Analyses

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

November 7, 2024
2 p.m.

Public health response teams, ch 113;
EMS, ch 131; EMS program, ch 132;
white flashing light, ch 133; trauma
care facility, ch 134; trauma triage and
transfer, ch 135; trauma registry, ch
136; trauma education and training, ch
137; EMS—training programs—
students—complaints and
investigations, ch 139; EMS grants
fund, ch 140; out-of-hospital do-not-
resuscitate orders, ch 142; automated
external defibrillator maintenance, ch
143; regionalized perinatal health care,
ch 150; substance abuse treatment and
assessment and the OWI law
IAB 10/16/24

Regulatory Analyses

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

November 6, 2024
10 a.m.

PUBLIC HEALTH DEPARTMENT[641](cont'd)

Interagency coordinating council for the
state medical examiner, ch 124
IAB 10/16/24

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

November 12, 2024
1 p.m.

Regulatory Analyses**PUBLIC SAFETY DEPARTMENT[661]**

Standards for electrical work; electrical
inspection program—organization and
administration, definitions, permits
and inspections, utility notifications
and responsibilities of utilities; civil
penalties, rescind chs 504, 550 to 553,
559; adopt ch 550
IAB 10/2/24

Ledges Conference Room
6200 Park Avenue
Des Moines, Iowa

October 22, 2024
9:30 to 10 a.m.

Regulatory Analysis**RACING AND GAMING COMMISSION[491]**

Sports wagering; fantasy sports contests,
13.2, 13.5, 13.6(3), 14.7(2), 14.8(1)
IAB 10/16/24

Commission Office
6200 Park Avenue, Suite 100
Des Moines, Iowa

November 6, 2024
9 a.m.

Regulatory Analysis

Sports wagering; fantasy sports contests,
13.2, 13.6(3), 14.8
IAB 10/2/24

Commission Office
6200 Park Avenue, Suite 100
Des Moines, Iowa

October 22, 2024
9 a.m.

Regulatory Analysis**TRANSPORTATION DEPARTMENT[761]**

Contested cases, ch 13
IAB 10/16/24 **ARC 8245C**

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 573 926 021

November 7, 2024
10 to 10:30 a.m.

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 526 404 95

November 8, 2024
11 to 11:30 a.m.

Interest on retained funds, ch 27
IAB 10/2/24

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 912 076 967

October 28, 2024
10 to 10:30 a.m.

Regulatory Analysis

Recovery of damages to highways or
highway structures, ch 40
IAB 10/2/24

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 611 359 34

October 28, 2024
11 to 11:30 a.m.

Regulatory Analysis

Secondary road fund distribution
methodology, ch 103
IAB 10/2/24

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 255 254 876

October 24, 2024
1 to 1:30 p.m.

Regulatory Analysis

TRANSPORTATION DEPARTMENT[761](cont'd)

Holiday rest stops, ch 105 IAB 10/16/24 ARC 8246C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 459 079 854 Microsoft Teams link Or dial: 515.817.6093 Conference ID: 722 926 003	November 6, 2024 11 to 11:30 a.m. November 7, 2024 2 to 2:30 p.m.
Real property acquisition and relocation assistance, ch 111 IAB 10/16/24 ARC 8250C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 484 679 961 Microsoft Teams link Or dial: 515.817.6093 Conference ID: 887 511 409	November 7, 2024 11 to 11:30 a.m. November 8, 2024 9 to 9:30 a.m.
Primary highway access control, ch 112 IAB 10/16/24 ARC 8251C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: Microsoft Teams link Or dial: 515.817.6093 Conference ID:	November 7, 2024 9 to 9:30 a.m. November 7, 2024 1 to 1:30 p.m.
Utility accommodation, ch 115 IAB 10/2/24 Regulatory Analysis	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 826 453 498	October 28, 2024 1 to 1:30 p.m.
Junkyard control, ch 116 IAB 10/16/24 ARC 8247C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 536 436 610 Microsoft Teams link Or dial: 515.817.6093 Conference ID: 769 718 494	November 6, 2024 9 to 9:30 a.m. November 8, 2024 1 to 1:30 p.m.
Outdoor advertising, ch 117 IAB 10/16/24 ARC 8248C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: Microsoft Teams link Or dial: 515.817.6093 Conference ID:	November 6, 2024 10 to 10:30 a.m. November 8, 2024 2 to 2:30 p.m.
Logo signing, ch 118 IAB 10/16/24 ARC 8249C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: Microsoft Teams link Or dial: 515.817.6093 Conference ID:	November 6, 2024 1 to 1:30 p.m. November 8, 2024 10 to 10:30 a.m.
Tourist-oriented directional signing, ch 119 IAB 10/16/24 ARC 8252C	Microsoft Teams link Or dial: 515.817.6093 Conference ID: Microsoft Teams link Or dial: 515.817.6093 Conference ID:	November 6, 2024 2:30 to 3 p.m. November 8, 2024 9 to 9:30 a.m.

TRANSPORTATION DEPARTMENT[761](cont'd)

Automated traffic enforcement mobile systems, ch 145 IAB 10/16/24	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 722 926 003	November 8, 2024 10 to 10:30 a.m.
Surface transportation block grant program, ch 162 IAB 10/2/24	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 938 298 103	October 24, 2024 11 to 11:30 a.m.
Regulatory Analysis		

Vehicle registration and certificate of title, ch 400 IAB 10/2/24	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 231 627 177	October 24, 2024 9 to 9:30 a.m.
Regulatory Analysis		

Driver education, ch 634 IAB 10/2/24	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 343 768 039	October 25, 2024 10 to 10:30 a.m.
Regulatory Analysis		

UTILITIES COMMISSION[199]

Restoration of agricultural lands during and after pipeline construction, ch 9 IAB 9/18/24 ARC 8219C	Commission Hearing Room 1375 East Court Avenue Des Moines, Iowa	October 17, 2024 2 to 4 p.m. October 31, 2024 9 to 11 a.m.

Service supplied by water, sanitary sewage, and storm water drainage utilities, ch 21 IAB 10/2/24 ARC 8229C	Commission Hearing Room 1375 East Court Avenue Des Moines, Iowa	October 24, 2024 2 to 4 p.m. November 4, 2024 2 to 4 p.m.

Energy efficiency and demand response planning and reporting for rate-regulated natural gas and electric utilities, ch 35 IAB 10/2/24 ARC 8230C	Commission Hearing Room 1375 East Court Avenue Des Moines, Iowa	October 23, 2024 9 to 11 a.m. November 13, 2024 2 to 4 p.m.

Ratemaking principles proceeding, ch 41 IAB 9/18/24 ARC 8213C	Commission Hearing Room 1375 East Court Avenue Des Moines, Iowa	October 29, 2024 2 to 4 p.m. November 12, 2024 2 to 4 p.m.

WORKFORCE DEVELOPMENT DEPARTMENT[871]

Employer's contribution and charges, ch 23 IAB 10/2/24	1000 East Grand Avenue Des Moines, Iowa	October 22, 2024 9 to 10 a.m.
Regulatory Analysis		

The following list will be updated as changes occur.

“Umbrella” agencies and elected officials are set out below at the left-hand margin in CAPITAL letters.

Divisions (boards, commissions, etc.) are indented and set out in lowercase type under their statutory “umbrellas.”

Other autonomous agencies are included alphabetically in SMALL CAPITALS at the left-hand margin.

ADMINISTRATIVE SERVICES DEPARTMENT[11]
AGING, DEPARTMENT ON[17]
AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]
 Soil Conservation and Water Quality Division[27]
ATTORNEY GENERAL[61]
AUDITOR OF STATE[81]
BEEF CATTLE PRODUCERS ASSOCIATION, IOWA[101]
BLIND, DEPARTMENT FOR THE[111]
CHIEF INFORMATION OFFICER, OFFICE OF THE[129]
OMBUDSMAN[141]
CIVIL RIGHTS COMMISSION[161]
INSURANCE AND FINANCIAL SERVICES DEPARTMENT[181]
 Alcoholic Beverages Division[185]
 Banking Division[187]
 Credit Union Division[189]
 Insurance Division[191]
 Professional Licensing and Regulation Bureau[193]
 Accountancy Examining Board[193A]
 Architectural Examining Board[193B]
 Engineering and Land Surveying Examining Board[193C]
 Landscape Architectural Examining Board[193D]
 Real Estate Commission[193E]
 Real Estate Appraiser Examining Board[193F]
 Interior Design Examining Board[193G]
UTILITIES COMMISSION[199]
CORRECTIONS DEPARTMENT[201]
 Parole Board[205]
CULTURAL AFFAIRS DEPARTMENT[221]
 Historical Division[223]
ECONOMIC DEVELOPMENT AUTHORITY[261]
 City Development Board[263]
IOWA FINANCE AUTHORITY[265]
EDUCATION DEPARTMENT[281]
 Educational Examiners Board[282]
 College Student Aid Commission[283]
 Higher Education Loan Authority[284]
 Libraries and Information Services Division[286]
 Public Broadcasting Division[288]
 School Budget Review Committee[289]
EGG COUNCIL, IOWA[301]
ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]
EXECUTIVE COUNCIL[361]
FAIR BOARD[371]
HUMAN RIGHTS DEPARTMENT[421]
HUMAN SERVICES DEPARTMENT[441]
INSPECTIONS AND APPEALS DEPARTMENT[481]
 Employment Appeal Board[486]
 Child Advocacy Board[489]
 Racing and Gaming Commission[491]
 State Public Defender[493]
IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495]

IOWA PUBLIC INFORMATION BOARD[497]
LAW ENFORCEMENT ACADEMY[501]
LIVESTOCK HEALTH ADVISORY COUNCIL[521]
LOTTERY AUTHORITY, IOWA[531]
MANAGEMENT DEPARTMENT[541]
 Appeal Board, State[543]
 City Finance Committee[545]
 County Finance Committee[547]
NATURAL RESOURCES DEPARTMENT[561]
 Environmental Protection Commission[567]
 Natural Resource Commission[571]
 Preserves, State Advisory Board for[575]
PETROLEUM UNDERGROUND STORAGE TANK FUND BOARD, IOWA COMPREHENSIVE[591]
PROPANE EDUCATION AND RESEARCH COUNCIL, IOWA[599]
PUBLIC DEFENSE DEPARTMENT[601]
HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]
PUBLIC EMPLOYMENT RELATIONS BOARD[621]
PUBLIC HEALTH DEPARTMENT[641]
 Professional Licensure Division[645]
 Dental Board[650]
 Medicine Board[653]
 Nursing Board[655]
 Pharmacy Board[657]
PUBLIC SAFETY DEPARTMENT[661]
RECORDS COMMISSION[671]
REGENTS BOARD[681]
 Archaeologist[685]
REVENUE DEPARTMENT[701]
SECRETARY OF STATE[721]
SHEEP AND WOOL PROMOTION BOARD, IOWA[741]
TELECOMMUNICATIONS AND TECHNOLOGY COMMISSION, IOWA[751]
TRANSPORTATION DEPARTMENT[761]
TREASURER OF STATE[781]
TURKEY MARKETING COUNCIL, IOWA[787]
VETERANS AFFAIRS, IOWA DEPARTMENT OF[801]
VETERINARY MEDICINE BOARD[811]
VOLUNTEER SERVICE, IOWA COMMISSION ON[817]
VOTER REGISTRATION COMMISSION[821]
WORKFORCE DEVELOPMENT DEPARTMENT[871]
 Labor Services Division[875]
 Workers' Compensation Division[876]
 Workforce Development Board and Workforce Development Center Administration Division[877]

Regulatory Analysis

Notice of Intended Action to be published: rule 281—12.3(256)
“Administration”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 256.7(5)

State or federal law(s) implemented by the rulemaking: 2023 Iowa Acts, Senate File 496

Public Hearing

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

November 5, 2024
8 to 9:30 a.m.

Room B50
Grimes State Office Building
Des Moines, Iowa

Public Comment

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

Thomas A. Mayes, General Counsel
Grimes State Office Building
400 East 14th Street
Des Moines, Iowa 50319
Phone: 515.281.8661
Email: thomas.mayes@iowa.gov

Purpose and Summary

This proposed rulemaking implements provisions of 2023 Iowa Acts, Senate File 496, that had not already been implemented by rulemaking.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
School districts will bear the cost of compliance with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Schools and communities will benefit from the clarity about Senate File 496 that this proposed rulemaking would provide.
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:
There is no known quantitative impact.
 - Qualitative description of impact:
The clarity that the proposed rulemaking provides is anticipated to have a qualitative benefit of unknown magnitude.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

The Department will bear routine enforcement costs (e.g., the costs of monitoring and enforcing any school law).

- Anticipated effect on state revenues:
None were noted.

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

The statute requires rules, so no comparison is necessary.

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

The statute requires rules, so no determination is necessary.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
The statute requires rules, so no alternatives were considered.
- Reasons why alternative methods were rejected in favor of the proposed rulemaking:
The statute requires rules, so no alternatives were considered.

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?

There is no known impact on small business.

Text of Proposed Rulemaking

ITEM 1. Amend paragraph **12.3(10)“b”** as follows:

b. Each school district shall establish a kindergarten through grade 12 library program that is consistent with Iowa Code section 280.6 and with the educational standards established in this chapter, that contains only age-appropriate materials, and that supports the student achievement goals of the total school curriculum. In complying with the requirements in Iowa Code section 279.77(3), the district, if it does not make available a comprehensive list of all books available to all students in libraries offered by the district on its website in real time, must post an updated list at least two times per calendar year.

ITEM 2. Adopt the following **new** paragraph **12.3(10)“c”**:

c. Support, monitoring, and enforcement.

(1) If, after investigation, the department determines that a school district or an employee of a school district has violated the provisions of this paragraph related to library programs containing only age-appropriate materials, beginning January 1, 2024, the school district or employee of the school district, as applicable, shall be subject to the following:

1. For the first violation of this paragraph, the department shall issue a written warning to the board of directors of the school district or the employee, as applicable.

2. For a second or subsequent violation of this paragraph, if the department finds that a school district knowingly violated this paragraph, the superintendent of the school district shall be subject to a hearing conducted by the board of educational examiners, which may result in disciplinary action.

3. For a second or subsequent violation of this paragraph, if the department finds that an employee of the school district who holds a license, certificate, authorization, or statement of recognition issued by the board of educational examiners knowingly violated this paragraph, the employee shall be subject to a hearing conducted by the board of educational examiners, which may result in disciplinary action.

(2) This paragraph relates solely to library programs operated by the district, which means library programs over which the district exercises administrative control.

(3) Concerning enforcement provisions relating to library books containing only age-appropriate materials, the department may exercise enforcement discretion if any violation is voluntarily and permanently corrected prior to the department making a determination of a violation.

(4) For library collections that serve multiple grade ranges, the district will exercise reasonable physical, administrative, and technological controls to ensure that students have access to age-appropriate materials based on the students' age and grade.

ITEM 3. Adopt the following **new** subrule 12.3(15):

12.3(15) *Compliance with Iowa Code section 279.80.*

a. A school district shall not provide any program, curriculum, test, survey, questionnaire, promotion, or instruction relating to gender identity or sexual orientation to students in kindergarten through grade six.

b. "Gender identity" and "sexual orientation" have the same meanings given in Iowa Code section 216.2.

c. In monitoring and enforcing this subrule, the department will not conclude that a neutral statement regarding sexual orientation or gender identity violates Iowa Code section 279.80 or this subrule.

Regulatory Analysis

Notice of Intended Action to be published: rule 281—31.5(299,299A)
“Dual Enrollment”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 256.7(5)
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 299A

Public Hearing

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

November 5, 2024
8 to 9:30 a.m.

Room B50
Grimes State Office Building
Des Moines, Iowa

Public Comment

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

Thomas A. Mayes, General Counsel
Grimes State Office Building
400 East 14th Street
Des Moines, Iowa 50319
Phone: 515.281.8661
Email: thomas.mayes@iowa.gov

Purpose and Summary

This proposed rulemaking clarifies language about coursework limits for dual enrollment. The current rule, although a correct statement of the State Board’s intent, is not a model of clarity. This anticipated rulemaking revises subrule 31.5(4) by using clearer language to express the State Board’s intent.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
School districts will bear the cost of compliance with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Schools and communities will benefit from the clarity about the rights of parents to access dual enrollment.
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:
There is no known quantitative impact.
 - Qualitative description of impact:
The clarity that the proposed rulemaking provides is anticipated to have a qualitative benefit of unknown magnitude.
3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
The Department will bear routine enforcement costs (e.g., the costs of monitoring and enforcing any school law).
 - Anticipated effect on state revenues:
None were noted.
4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:
The statute requires rules, so no comparison is necessary.
5. Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:
The statute requires rules, so no determination is necessary.
6. Alternative methods considered by the agency:
- Description of any alternative methods that were seriously considered by the agency:
The statute requires rules, so no alternatives were considered.
 - Reasons why alternative methods were rejected in favor of the proposed rulemaking:
The statute requires rules, so no alternatives were considered.

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?

There is no known impact on small business.

Text of Proposed Rulemaking

- ITEM 1. Rescind subrule 31.5(4) and adopt the following **new** subrule in lieu thereof:
31.5(4) A parent may not use dual enrollment to enroll a child in all courses but one.

Regulatory Analysis

Notice of Intended Action to be published: 421—Chapter 40
“Functions of Division”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 216A
State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 12, 2024
1 p.m.

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

Public Comment

Any interested person may submit written 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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed rulemaking is to rescind a chapter that is no longer applicable due to the passage of 2024 Iowa Acts, Senate File 2385, which consolidated Iowa’s boards and commissions.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
There is no particular benefit or detriment as a result of the rulemaking.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
One administrative chapter is eliminated.
 - Qualitative description of impact:
References in administrative rules to offices and commissions that no longer exist are eliminated.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
There are no costs associated with this rulemaking.
 - Anticipated effect on state revenues:
This rulemaking has no impact on state revenues.

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

The rulemaking is necessitated by 2024 Iowa Acts, Senate File 2385.

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:

None.

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

This rulemaking is necessitated by 2024 Iowa Acts, Senate File 2385.

Small Business Impact

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

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

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

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **421—Chapter 40.**

Regulatory Analysis

Notice of Intended Action to be published: 421—Chapter 41
“Hall of Fame”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 216A
State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 12, 2024
1 to 2 p.m.

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

Public Comment

Any interested person may submit written 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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This rulemaking eliminates an administrative chapter that has become obsolete due to the enactment of 2024 Iowa Acts, Senate File 2385.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
There is no particular benefit or detriment from the rulemaking.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
One administrative chapter will be eliminated.
 - Qualitative description of impact:
Unknown.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
There are no costs associated with this rulemaking.
 - Anticipated effect on state revenues:
This rulemaking has no effect on state revenues.

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

Inaction is not possible; there is no rulemaking authority for this chapter.

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

The only option is to rescind the chapter.

6. Alternative methods considered by the agency:

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

None.

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

There is no rulemaking authority for this chapter.

Small Business Impact

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

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

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

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **421—Chapter 41**.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 36
“Facility Assessments”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A.21, 249L.4 and 249M.4

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 249A, 249L and 249M

Public Hearing

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

November 7, 2024
10 a.m.

Microsoft Teams
Meeting ID: 295 147 282 130
Passcode: jm6rgf

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines the quality assurance assessment fee (QAAF) for nursing facilities, provider taxes for Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID), and health care access assessments for hospitals pursuant to Iowa Code chapters 249A, 249L, and 249M.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with the rulemaking itself.
 - Classes of persons that will benefit from the proposed rulemaking:
Individuals covered by Medicaid who utilize participating facilities in Iowa will benefit.
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:
Information is not available at this time.
 - Qualitative description of impact:
Information is not available at this time.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
Personnel and other administrative costs are borne by the agency.
 - Anticipated effect on state revenues:

No effect on state revenues is anticipated as a result of the rulemaking.

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

The rules provide guidance to participating facilities on how the Hospital Health Care Access Trust Fund is administered and how reimbursements and expenditures from the Trust Fund would be facilitated.

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

Rulemaking is appropriate and required.

6. Alternative methods considered by the agency:

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

None were considered because rules are required by the Iowa Code.

- 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 rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 36 and adopt the following **new** chapter in lieu thereof:

CHAPTER 36 FACILITY ASSESSMENTS

441—36.1(249A) Assessment of fee. Intermediate care facilities for persons with an intellectual disability (ICFs/ID) licensed in Iowa under 481—Chapter 64, including facilities not certified to participate in the Medicaid program, shall pay a quarterly fee to the department. The fee equals 5.5 percent of actual paid claims, from all sources, for the facility's preceding quarter.

441—36.2(249A) Determination and payment of fee. For all ICFs/ID licensed in Iowa under 481—Chapter 64, including facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) Each facility shall pay the assessment to the department on a quarterly basis. The facility shall:

- a. Use a form prescribed by the department to calculate the quarterly fee due.

b. Submit the form and the quarterly fee no later than 30 days following the end of each calendar quarter.

36.2(2) The facility shall calculate the amount of the quarterly fee due by multiplying 5.5 percent by the facility's total ICF/ID payments for services received from all sources during the preceding quarter, including but not limited to:

- a. Medicaid managed care payments.
- b. Client participation payments.
- c. Medicaid fee-for-service payments.
- d. Private pay/insurance payments.
- e. Ancillary service payments.

36.2(3) If the department determines that an ICF/ID has underpaid or overpaid the fee, the department will notify the ICF/ID of the amount of the unpaid fee or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.2(4) An ICF/ID that fails to pay the fee within 30 days of the issuance of the notice shall pay a penalty in the amount of 1.5 percent of the unpaid fee due for each month or portion of a month that the unpaid fee is overdue.

a. If the ICF/ID substantiates good cause beyond the facility's control for failure to make timely payment of the fee, the department will waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" means the same as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the department within 30 days of notice to the facility that the penalty is due.

36.2(5) If a fee has not been received by the department by the last day of the month following the end of the quarter, the department will suspend payment due the ICF/ID under the medical assistance program, including payments made on behalf of the medical assistance program by a contracted managed care organization.

441—36.3(249L) Assessment.

36.3(1) *Applicability.* All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under this division, with the exception of:

- a. Nursing facilities operated by the state.
- b. Non-state government-owned or government-operated nursing facilities.
- c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

36.3(2) *Assessment level.*

a. Effective April 1, 2023, nursing facilities with 46 or fewer licensed beds are required to pay a quality assurance assessment of \$6.51 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2021, the number of licensed beds on file with the department of inspections, appeals, and licensing as of June 1 of each year shall be used to determine the assessment level for the following state fiscal year.

b. Effective July 1, 2024, nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the department of insurance and financial services are required to pay a quality assurance assessment of \$6.51 per non-Medicare patient day. Effective with the assessment for the state fiscal year beginning July 1, 2021, continuing care retirement center designations as of June 1 of each year shall be used to determine the assessment level for the following state fiscal year.

c. Effective April 1, 2023, nursing facilities with annual Iowa Medicaid patient days of 19,000 or more are required to pay a quality assurance assessment of \$6.51 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2021, the annual number of Iowa Medicaid patient days reported in the most current cost report submitted to the department as of June 1 of each year shall be used to determine the assessment level for the following state fiscal year.

d. Effective April 1, 2023, all other nursing facilities are required to pay a quality assurance assessment of \$33.90 per non-Medicare patient day.

441—36.4(249L) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.4(1) Each nursing facility shall pay the quality assurance assessment to the department on a quarterly basis. The facility shall:

- a.* Use the form prescribed by the department to calculate the quarterly assessment amount due.
- b.* Submit the form and the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.4(2) The facility shall calculate the amount of the quarterly assessment due by multiplying the facility's total non-Medicare patient days for the preceding quarter by the applicable assessment level as determined in subrule 36.3(2).

36.4(3) If the department determines that a nursing facility has underpaid or overpaid the quality assurance assessment, the department will notify the nursing facility of the amount of the unpaid quality assurance assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.4(4) A nursing facility that fails to pay the quality assurance assessment within 30 days of the issuance of the notice will pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the facility substantiates good cause beyond the facility's control for failure to comply with payment of the quality assurance assessment, the department will waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" means the same as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the department within 30 days of notice to the facility that the penalty is due.

36.4(5) For facilities certified to participate in the Medicaid program, the department will deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the quality assurance assessment amount due by the last day of the month in which the payment is due. The department will also withhold an amount equal to the penalty owed from any payment due.

36.4(6) If the quality assurance assessment has not been received by the department by the last day of the month following the end of the quarter, the department will suspend payment due the nursing facility under the medical assistance program, including payments made on behalf of the medical assistance program by a contracted managed care organization.

441—36.5(249M) Application of assessment.

36.5(1) *Participating hospitals.* For the purpose of the health care access assessment program, a "participating hospital" is defined as a non-state-owned hospital licensed under Iowa Code chapter 135B that is paid on a prospective payment system basis by Medicare and the medical assistance programs for inpatient and outpatient services.

36.5(2) *Assessment.* Participating hospitals are required to pay a quarterly health care access assessment equal to 1.26 percent of net patient revenue as specified in the hospital's fiscal year 2008 Medicare cost report. "Net patient revenue" means all revenue reported for acute patient care and services but does not include:

- a.* Contractual adjustments,
- b.* Charity care,
- c.* Bad debt,
- d.* Medicare revenue, or
- e.* Other revenue derived from sources other than hospital operations including but not limited to:
 - (1) Nonoperating revenue,

- (2) Other operating revenue,
- (3) Skilled nursing facility revenue,
- (4) Physician revenue, and
- (5) Long-term care revenue.

441—36.6(249M) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.6(1) The department will calculate the annual amount of the health care access assessment as 1.26 percent of net patient revenue as specified in the participating hospital's fiscal year 2008 Medicare cost report. The annual amount will be divided by four to calculate the quarterly amount.

36.6(2) Each participating hospital shall pay the health care access assessment to the department on a quarterly basis. The hospital shall submit the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.6(3) A participating hospital shall retain and preserve the Medicare cost report and financial statements used to prepare the cost report in accordance with Iowa Code section 249M.3.

36.6(4) If the department determines that a participating hospital has underpaid or overpaid the health care access assessment, the department will notify the hospital of the amount of the unpaid health care access assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.6(5) A participating hospital that fails to pay the health care access assessment within 30 days of the issuance of the notice will pay a penalty in the amount of 1.5 percent of the health care access assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the department determines that good cause is shown for failure to comply with payment of the health care access assessment, the department will waive the penalty or a portion of the penalty.

b. Requests for a good cause waiver must be submitted to the department within 30 days of notice to the facility that the penalty is due.

36.6(6) The department will deduct the quarterly amount due from Medicaid payments to the participating hospital if the department has not received the health care access assessment by the last day of the month in which the payment is due. The department will also withhold an amount equal to the penalty owed from any payment due.

36.6(7) If a health care access assessment has not been received by the department by the last day of the month following the end of the quarter, the department will suspend payment due the participating hospital under the medical assistance program, including payments made on behalf of the medical assistance program by a contracted managed care organization.

These rules are intended to implement Iowa Code chapters 249A, 249L, and 249M.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 40
“Application for Aid”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 239B.4(6)

State or federal law(s) implemented by the rulemaking: Iowa Code sections 239B.2, 239B.3, 239B.4, 239B.5, 239B.6, 239B.13 and 239B.18

Public Hearing

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

November 7, 2024
10 a.m.

Microsoft Teams
Meeting ID: 295 147 282 130
Passcode: jm6rgf

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter contains definitions and provides the application process for the Family Investment Program (FIP), the effective date of the grant, the review process, and investigations.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Persons applying for the FIP grant will benefit.
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:
For state fiscal year 2023, there were approximately 11,011 clients on average per month enrolled in the FIP.
 - Qualitative description of impact:
These rules play an important role in providing structure, specificity, and a legal basis for decisions made by the Department.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

The Department incurs personnel costs to implement the program and costs for postage for review forms.

- Anticipated effect on state revenues:

There are no additional costs beyond those already appropriated.

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

If this chapter did not exist, there would not be a consistent, fair, and equitable program.

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

A less costly method has not been identified to achieve the purpose of this rulemaking.

6. Alternative methods considered by the agency:

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

None were considered.

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

Some of the benefit can be achieved through forms prescribed by the Department or employee manuals. However, additional structure is needed to provide a framework and a legal basis for decisions made by the Department.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 40 and adopt the following **new** chapter in lieu thereof:

TITLE IV
FAMILY INVESTMENT PROGRAM
CHAPTER 40
APPLICATION FOR AID

441—40.1(239B) Definitions.

“*Applicant*” means a person for whom assistance is being requested, parent(s) living in the home with the child(ren), and the nonparental relative as defined in 441—subrule 41.2(2) who is requesting assistance for the child(ren).

“*Assistance unit*” includes any person whose income is considered when determining eligibility or the family investment program grant amount.

“Casino, gambling casino, or gaming establishment” means an establishment with a primary purpose of accommodating the wagering of money. It does not include:

1. A grocery store that sells groceries including staple foods and that also offers, or is located within the same building or complex as, casino, gambling, or gaming activities; or
2. Any other establishment that offers casino, gambling, or gaming activities incidental to the principal purpose of the business.

An automated teller machine (ATM) or a point-of-sale (POS) terminal located within those areas of an establishment where individuals are banned due to age restrictions associated with gambling, established by state or federal law or by any other regulatory entity having the authority to do so, is considered to be in a casino, gambling casino, or gaming establishment.

“Central office” means the state administrative office of the department of health and human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or *“dependent children”* means a child or children who meet the nonfinancial eligibility requirements of the family investment program.

“Electronic benefit transfer transaction” means the use of a credit or debit card service, automated teller machine, point-of-sale terminal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service.

“Income in kind” is any gain or benefit that is not in the form of money payable directly to the eligible group including nonmonetary or in-kind benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments that are paid to a third party and not to the eligible group.

“Initial two months” means the first two consecutive months for which assistance is paid. This may include a month for which a partial payment is made.

“Liquor store” means any retail establishment that sells exclusively or primarily intoxicating liquor or other alcoholic beverages. Such term does not include a grocery store that sells both intoxicating liquor and groceries including staple foods (within the meaning of Section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. §2012(r))).

Unless exempt as described in this definition, a retail establishment meets the definition of a liquor store when it has a North American Industry Classification System (NAICS) number that categorizes the retail establishment as either a beer, wine and liquor store or as a drinking place (alcoholic beverages). A retail establishment that does not have either type of NAICS code is considered to exclusively or primarily sell intoxicating liquor when 95 percent or more of the retail establishment’s gross sales are from intoxicating liquor and it is not a United States Department of Agriculture-certified Supplemental Nutrition Assistance Program (SNAP) retailer.

“Medical institution,” as used in this title, means a facility that is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

“Needy specified relative” means a nonparental specified relative, listed in 441—subrule 41.2(2), who meets all the eligibility requirements to be included in the family investment program.

“Parent” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“Payment month” means the calendar month for which assistance is paid.

“Payment standard” means the total needs of a group as determined by adding need according to the schedule of basic needs, described in 441—subrule 41.9(2), to any allowable special needs, described in 441—subrule 41.9(3).

“Prospective budgeting” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances that will exist in that calendar month.

“Qualified alien” means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is admitted to the United States as an Amerasian as described in 8 U.S.C. §1612(b)(2)(A)(ii)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. §1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. §1641(c); or
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

“Qualifying quarters” means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act that were worked by a parent of an alien while the alien was under the age of 18 and all of the qualifying quarters that were worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

“Recipient” means a person for whom assistance is paid, parent(s) living in the home with the eligible child(ren) and nonparental relative as defined in 441—subrule 41.3(1) who is receiving assistance for the child(ren). Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“Retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment” means an establishment that includes live entertainment at locations such as, but not limited to, strip clubs and gentlemen’s clubs. It also includes stores and theaters that exclusively or primarily sell or feature adult-oriented videos and movies such as, but not limited to, adult book stores and adult movie theaters. A retail establishment meets this definition when the department has confirmed the primary nature of the business through the description on the business’s website, phone contact with the establishment, a site visit, or other means such as common local knowledge.

“Standard of need” means the total needs of a group as determined by adding need according to the schedule of living costs, described in 441—subrule 41.9(2), to any allowable special needs, described in 441—subrule 41.9(3).

“Stepparent” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent, by ceremonial or common-law marriage.

“Unborn child” will include an unborn child during the entire term of the pregnancy.

441—40.2(239B) Application. The application for the family investment program shall be submitted on an application form prescribed by the department. The application shall be signed by the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and attest to the information for the assistance unit.

40.2(1) Each individual wishing to do so will have the opportunity to apply for assistance without delay. When the parent is in the home with the child and is not prevented from acting as payee by reason of physical or mental impairment, this parent shall make the application.

40.2(2) An applicant may be assisted by other individuals in the application process; the client may be accompanied by such individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

40.2(3) The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department will send the necessary forms in the next outgoing mail.

40.2(4) A new application is not required when adding a new person to the eligible group or when a parent or a stepparent becomes a member of the household.

40.2(5) Reinstatement.

a. Assistance will be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished, or the family meets the conditions described in 441—subparagraph 41.11(3)“e”(7). Exception: The reinstatement provisions of subrule 40.2(5) do not apply when assistance is canceled due to the imposition of a subsequent limited benefit plan as described in 441—subrule 41.5(7), unless the limited benefit plan is stopped as described in 441—paragraph 41.5(7)“g.”

b. When assistance has been canceled for failure to provide requested information, assistance will be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date all information required to establish eligibility is provided.

c. When assistance has been canceled for failure to return a completed review form pursuant to subrule 40.7(3), assistance will be reinstated without a new application if the completed form is received by the department within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date the review form prescribed by the department is received.

d. When assistance has been canceled for failure to complete a required review interview, assistance will be reinstated without a new application if the interview is completed and all necessary information to determine eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility is reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date the interview is completed.

441—40.3(239B) Date of application. The date of application is the date the application form prescribed by the department is received by the department. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open.

40.3(1) The date of application is also the date an identifiable application is received by a designated worker who is in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center or other facility

will forward the application to the department office that is responsible for the completion of the eligibility determination.

40.3(2) An identifiable application is an application containing a legible name and address that has been signed.

40.3(3) A new application is not required when adding a person to an existing eligible group. This person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person will be the date of the report.

a. In those instances where a person previously excluded from the eligible group as described in 441—subrule 41.8(11) is to be added to the eligible group, the date of application to add the person is the date the person indicated willingness to cooperate.

b. Exceptions:

(1) When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.3(11), the date of application to add the person is the date the social security number or proof of application for a social security number is provided.

(2) When adding a person who was previously excluded from the eligible group as described in 441—subrule 41.4(5), 441—subrule 41.6(4), or rule 441—46.7(239B), the date of application to add the person is the first day after the period of ineligibility has ended.

(3) When adding a person who was previously excluded from the eligible group as described in 441—subrule 41.5(7), the date of application to add the person is the date the person signs a family investment agreement.

40.3(4) Grace period.

a. When an application has been denied for failure to provide requested information, if all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date all of the information is provided.

b. When an application has been denied for failure to attend an interview, if the interview is completed and all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date the interview is completed or the date all of the information is provided, whichever is later.

441—40.4(239B) Procedure with application.

40.4(1) The decision with respect to eligibility will be based primarily on information furnished by the applicant.

a. The applicant shall report no later than at the time of the interview any change as defined in paragraph 40.7(4)“*e*” that occurs after the application was signed. Any change that occurs after the interview shall be reported by the applicant within five days from the date the change occurred.

b. The department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources will serve as a basis for denial of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

(1) Five working days will be considered as a reasonable period for the applicant to supply the required information or verification. The department will extend the deadline when the applicant requests an extension because the applicant is making every effort to supply the information or verification but is unable to do so.

(2) “Supply” means the requested information is received by the department by the specified due date. Any time taken beyond the required time frame will be considered a delay on the part of the applicant.

c. When an individual is added to an existing eligible group, the five-day requirement for reporting changes will be waived. These individuals and eligible groups will be subject to the recipient’s ten-day reporting requirement as defined in subrule 40.7(4).

40.4(2) The department or the designated worker as described in subrule 40.3(1) will conduct a face-to-face or telephone interview with the applicant before approval of the application for assistance.

a. The worker will assist the applicant, when requested, in providing information needed to determine eligibility and the amount of assistance.

b. The application process shall include a visit, or visits, to the home of the child and the person with whom the child will live during the time assistance is granted under the following circumstances:

(1) When it is the judgment of the worker or the supervisor that a home visit is required to clarify or verify information pertaining to the eligibility requirements; or

(2) When the applicant requests a home visit for the purpose of completing a pending application.

c. When adding an individual to an existing eligible group, the interview requirement may be waived.

40.4(3) The decision with respect to eligibility will be based on the applicant’s eligibility or ineligibility on the date the department enters all eligibility information into the department’s computer system. The applicant shall become a recipient on the date all eligibility information is entered into the department’s computer system and the computer system determines the applicant is eligible for aid.

441—40.5(239B) Time limit for decision. A determination of approval or denial will be made as soon as possible, but no later than 30 days following the date of filing an application. A written notice of decision will be issued to the applicant the next working day following a determination of eligibility or ineligibility. This time standard shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department. When eligibility is dependent upon the birth of a child, the time limit may be extended while awaiting the birth of the child. When it becomes evident that due to an error on the part of the department, eligibility will not be established within the 30-day limit, the application will be approved pending a determination of eligibility.

441—40.6(239B) Effective date of grant. New approvals will be effective as of the date the applicant becomes eligible for assistance, but in no case will the effective date be earlier than seven days following the date of application. When an individual is added to an existing eligible group, the individual will be added effective as of the date the individual becomes eligible for assistance, but in no case will the effective date be earlier than seven days following the date the change is reported. When it is reported that a person is anticipated to enter the home, the effective date of assistance will be no earlier than the date of entry or seven days following the date of report, whichever is later.

40.6(1) When the change is timely reported as described in subrule 40.7(4), a payment adjustment will be made when indicated. When the individual’s presence is not timely reported as described in subrule 40.7(4), excess assistance issued is subject to recovery.

40.6(2) In those instances where a person previously excluded from the eligible group as described in 441—subrule 41.8(11) is to be added to the eligible group, the effective date of eligibility will be seven days following the date the person indicated willingness to cooperate. However, in no instance will the person be added until cooperation has actually occurred.

Exceptions: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.3(11), the effective date of eligibility will be seven days following the date that the social security number or proof of application for a social security number is provided.

40.6(3) When adding a person who was previously excluded from the eligible group as described in 441—subrules 41.4(5) and 41.6(4) and rule 441—46.7(239B), the effective date of eligibility will be seven days following the date that the period of ineligibility ended.

40.6(4) When adding a person who was previously excluded from the eligible group as described in 441—subrule 41.5(7), the effective date of eligibility will be seven days following the date the person signs a family investment agreement or the date the person is otherwise eligible, whichever is later. In no case will the effective date be within the six-month ineligibility period of a subsequent limited benefit plan as described in 441—paragraph 41.5(7) “a.”

441—40.7(239B) Continuing eligibility.

40.7(1) Eligibility factors will be reviewed at least every six months for the family investment program. An interview may be conducted at the time of a review.

40.7(2) A redetermination of specific eligibility factors will be made when:

- a. The recipient reports a change in circumstances.
- b. A change in the recipient’s circumstances comes to the attention of a staff member.

40.7(3) Information for semiannual reviews shall be submitted on a review form prescribed by the department.

a. The department will supply the review form to the recipient as needed or upon request. The department will pay the cost of postage to return the form.

(1) When the review form is issued in the department’s regular end-of-month mailing, the recipient shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department’s regular end-of-month mailing, the recipient shall return the completed form to the department by the seventh day after the date it is mailed by the department.

(3) A copy of a review form received by fax or electronically will have the same effect as an original form.

b. When the client has completed the application form prescribed by the department for another purpose, this form may be used as the review document.

c. The review form shall be signed by the payee, the payee’s authorized representative, or, when the payee is incompetent or incapacitated, someone acting responsibly on the payee’s behalf.

40.7(4) Responsibilities of recipients. For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility and the amount of the family investment program grant.

b. The recipient shall complete the required review form when requested by the department in accordance with subrule 40.7(3). Failure to return a completed form will result in cancellation of assistance. A completed form is a form with all items answered, signed, dated and accompanied by verification as required in 441—paragraphs 41.8(1) “e” and 41.8(2) “g.”

c. The recipient has the primary responsibility for providing information and verification needed to establish eligibility and the amount of the family investment program grant. The recipient shall supply, insofar as the recipient is able, information and verification needed within ten working days from the date a written request is mailed by the department to the recipient’s current mailing address or given to the recipient. The department will extend the deadline when the recipient requests an extension because the recipient is making every effort to supply the information or verification but is unable to do so.

(1) “Supply” means that the requested information or verification is received by the department by the specified due date.

(2) When the recipient is unable to furnish information or verification needed to establish eligibility and the amount of the family investment program grant, the recipient shall request assistance from the department.

(3) Failure to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources will serve as a basis for cancellation of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

d. The recipient or applicant shall cooperate with the department when the recipient’s or applicant’s case is selected by quality control for verification of eligibility. The recipient or applicant shall also cooperate with the front end investigations conducted by the department of inspections, appeals, and licensing to determine whether information supplied to the department by the client is complete and correct regarding pertinent public assistance information unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect family investment program eligibility (more information can be found in 481—Chapter 72). Failure to cooperate will serve as a basis for cancellation or denial of the family’s assistance. Once denied or canceled for failure to cooperate, the family may reapply but will not be considered for approval until cooperation occurs.

e. The recipient, or an individual being added to the existing eligible group, shall timely report any change in the following circumstances:

- (1) Beginning or ending income, including receipt of a nonrecurring lump sum.
- (2) Resources.
- (3) Members of the household.
- (4) School attendance of a child.
- (5) Mailing or living address.
- (6) Receipt of a social security number.

f. A report will be considered timely when made within ten days from:

- (1) The receipt of resources or income or the date income ended.
- (2) The date the address changes.
- (3) The date the child is officially dropped from the school rolls.
- (4) The date a person enters or leaves the household.
- (5) The receipt of a social security number.

g. When a change is not timely reported, any excess assistance paid will be subject to recovery.

40.7(5) After assistance has been approved, eligibility for continuing assistance and the amount of the grant will be effective as of the first of each month. Any change affecting eligibility or benefits reported during a month will be effective the first day of the next calendar month except as follows:

a. When the recipient reports a new person to be added to the eligible group, and that person meets eligibility requirements, a payment adjustment will be made for the month of report, subject to the effective date of grant limitations prescribed in rule 441—40.6(239B).

b. When cancellation of assistance occurs later because issuance of a timely notice, as required by rule 441—16.2(17A), requires that the action be delayed until the first day of the second calendar month, any overpayment received in the first calendar month will be recouped.

c. When the recipient reports a change in income or circumstances timely, as defined in subrule 40.4(1) or 40.7(4), the department will determine prospective eligibility and the grant amount for the following month based on the change.

(1) A payment adjustment will be made when indicated.

(2) Recoupment will be made for any overpayment, with one exception. When a change in income is timely reported by a recipient and timely acted upon by the department, but the timely notice, as required by rule 441—16.2(17A), requires the action be delayed until the second calendar month following the month of change, and eligibility continues, recoupment will not be made.

d. When an individual included in the eligible group becomes ineligible, that individual's needs will be removed prospectively effective the first day of the next calendar month. When the action must be delayed due to administrative requirements, a payment adjustment or recoupment will be made when appropriate.

e. When a sanction under 441—paragraph 41.3(4) “*f*” is implemented, the change will be effective:

(1) The first day of the next calendar month after the change has occurred when the income maintenance unit determines noncooperation; or

(2) After the income maintenance unit receives notification from the child support recovery unit when child support services determines noncooperation.

f. When a sanction under 441—paragraph 41.3(4) “*f*” is removed, the change will be effective the first day of the next calendar month after the recipient has expressed willingness to cooperate, as described in 441—paragraph 41.3(4) “*f*.” However, action to remove the sanction will be delayed until:

(1) Cooperation has actually occurred; or

(2) The income maintenance unit has received notification from child support services that the client has cooperated.

g. A different effective date will be applied when specifically indicated in family investment program rules, such as in 441—subrule 41.6(4) and 441—subparagraph 41.8(9) “*c*”(2).

441—40.8(239B) Referral for investigation. The department may refer questionable cases to the department of inspections, appeals, and licensing.

441—40.9(239B) Alternate payees.

40.9(1) *Conservatorship or guardianship.* When application for the family investment program is filed by a person under conservatorship or guardianship, a copy of the court order will be secured by the department. Assistance payments will be made pursuant to Iowa Code section 239B.13.

40.9(2) *Emergency payee.* Payments may be made to persons acting for relatives who have been receiving assistance for a child in emergency situations that deprive the child of the relatives' care. These payments will be made for a temporary period, not to exceed three months, to allow time to make and implement plans for the child's continuing care and support.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.4, 239B.5, 239B.6, 239B.13 and 239B.18.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 41
“Granting Assistance”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 239B.4(6)

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 239B and sections 239B.1, 239B.2, 239B.4, 239B.5 and 239B.7

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines the requirements for eligibility and granting assistance for the Family Investment Program (FIP).

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Persons applying for, or enrolled in, the FIP will benefit.
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:
For state fiscal year 2023, there were approximately 11,011 clients on average per month enrolled in the FIP.
 - Qualitative description of impact:
These rules provide clear and consistent eligibility criteria and requirements for granting assistance.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
The Department incurs personnel costs to implement the program.

- Anticipated effect on state revenues:

No additional costs beyond those already appropriated are anticipated.

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

If this chapter did not exist, there would not be a consistent, fair, and equitable program.

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

A less costly method has not been identified to achieve the purpose of this rulemaking.

6. Alternative methods considered by the agency:

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

None were considered.

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

Some of the benefit can be achieved through forms prescribed by the Department or employee manuals. This chapter clarifies specific policies and procedures and provides a legal basis for Department decisions but only within the scope of and as defined in the Iowa Code.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 41 and adopt the following **new** chapter in lieu thereof:

CHAPTER 41 GRANTING ASSISTANCE

441—41.1(239B) Definition.

“*PROMISE JOBS program*” means the same as defined in rule 441—93.1(239B).

441—41.2(239B) Eligibility factors specific to child.

41.2(1) Age.

a. The family investment program (FIP) will be available to a needy child under the age of 18 years without regard to school attendance.

b. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month. The FIP will also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or

technical training, as defined in paragraph 41.5(2) “c,” and who is reasonably expected to complete the program before reaching the age of 19.

41.2(2) *Residing with relative.* The child must be living in the home of one of the relatives specified in subrule 41.3(1). When an unwed mother intends to place her child for adoption shortly after birth, the child will be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child’s welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

441—41.3(239B) Eligibility factors specific to payee.

41.3(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child’s home is with one of the relatives listed in Iowa Code section 239B.1(13) or with a spouse of the relative even though the marriage is terminated by death or divorce.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

c. The FIP is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

d. The presence of an able-bodied stepparent in the home will not disqualify a child for assistance, provided that other eligibility factors are met.

41.3(2) *Liability of relatives.* All appropriate steps will be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity.

a. When necessary to establish eligibility, the income maintenance unit will make the initial contact with the absent parent at the time of application. Subsequent contacts will be made by child support services.

b. When contact with the FIP family or other sources of information indicate that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the income maintenance unit will contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.3(3) *Referral to child support services.* The income maintenance unit will provide prompt notice to child support services pursuant to Iowa Code section 239B.2(6).

a. A referral to child support services will not be made when a parent’s absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. “Prompt notice” means within two working days of the date assistance is approved.

41.3(4) *Cooperation in obtaining support.* Each applicant for or recipient of the FIP shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in subrule 41.3(6) for refusal to cooperate is established.

a. The applicant or recipient must cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the office of the income maintenance unit or child support services to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

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

(4) Paying to the department any cash support payments for a member of the eligible group, except as described in paragraph 41.8(7) “n,” received by a recipient after the date of decision as defined in 441—subrule 40.4(3).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the income maintenance unit in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to child support services.

d. The applicant or recipient shall cooperate with child support services to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state’s attorney for any relevant judicial or administrative process.

e. In the circumstance as described in subparagraph 41.3(4) “b”(4), the income maintenance unit will make the determination of whether or not the applicant or recipient has cooperated. In all other instances, child support services will make the determination of whether the applicant or recipient has cooperated. Child support services delegates the income maintenance unit to make this determination for applicants.

f. Failure to cooperate will result in a sanction to the family. The sanction will be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction will be implemented after the noncooperation has occurred. The sanction will remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction will be delayed until cooperation has occurred.

(2) When child support services makes the determination, the sanction will be implemented upon notification from child support services to the income maintenance unit that the client has failed to cooperate. The sanction will remain in effect until the client has expressed to either income maintenance or child support services staff willingness to cooperate. However, any action to remove the sanction will be delayed until income maintenance is notified by child support services that the client has cooperated.

41.3(5) *Assignment of support payments.*

a. Each applicant for or recipient of assistance shall assign to the department any rights to support pursuant to Iowa Code section 239B.6.

b. An assignment is effective the same date all eligibility information is entered into the department’s computer system and is effective for the entire period for which assistance is paid.

41.3(6) *Good cause for refusal to cooperate.* Good cause exists when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit will determine that cooperation is against the child’s best interest when the applicant’s or recipient’s cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought; or

(2) Emotional harm to the child for whom support is to be sought; or

(3) Physical harm to the parent or caretaker relative with whom the child is living that reduces the person’s capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit will determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm will be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the following will be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

41.3(7) *Claiming good cause.* Each applicant for or recipient of the FIP who is required to cooperate with child support services will have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the income maintenance unit will notify the applicant or recipient using a form prescribed by the department of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause will:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the FIP.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed; and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit will issue a second notice on a form prescribed by the department. To claim good cause, the applicant or recipient shall sign and date this form and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or recipient must provide corroborative evidence of a good cause circumstance and must, when requested, furnish sufficient information to permit the income maintenance unit to investigate the circumstances.

(2) Informs the applicant or recipient that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the department's investigation when necessary, the income maintenance unit will determine whether cooperation would be against the best interest of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that child support services may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that child support services may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements will constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

41.3(8) *Determination of good cause.* The income maintenance unit will determine whether good cause exists for each applicant for or recipient of the FIP who claims to have good cause.

a. The applicant or recipient shall be notified by the income maintenance unit of its determination that good cause does or does not exist. The determination will:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the FIP case record.

b. The determination of whether or not good cause exists will be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 41.3(9).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or recipient will be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The income maintenance unit will make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after the unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit will:

(1) Afford child support services the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from child support services.

f. Child support services may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance will not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under

which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit will:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

41.3(9) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or recipient needs additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit will allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records that indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records that indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

(4) Medical records that indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances that provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the income maintenance unit wishes to request additional corroborative evidence that is needed to permit a good cause determination, the income maintenance unit will:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document that is needed.

c. When the applicant or recipient requests assistance in securing corroborative evidence, the income maintenance unit will:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents that the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit will investigate the good cause claim when the unit believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and the investigation that is conducted satisfy the income maintenance unit that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.3(10) *Enforcement without caretaker's cooperation.* When the income maintenance unit makes a determination that good cause exists, the unit will also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve the participation of the child or caretaker.

a. Child support services will have an opportunity to review and comment on the findings and basis for the proposed determination, and the income maintenance unit will consider any recommendation from child support services.

b. The determination will:

(1) Be in writing,

(2) Contain the income maintenance unit's findings and basis for determination, and

(3) Be entered into the FIP case record.

c. When the income maintenance unit excuses cooperation but determines that child support services may proceed to establish paternity or enforce support, the income maintenance unit will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.3(11) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement will not apply to a payee who is not a member of the eligible group.

a. Assistance will not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of subrule 41.3(11).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described in subrule 41.4(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.3(12) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive FIP benefits unless good cause for not living with the parent or legal guardian is established.

a. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium or same row house as the adult parent or legal guardian. It also includes living in an apartment that is located in the home of the adult parent or legal guardian.

b. For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described in 441—subrule 40.4(1).

(1) If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child will

be approved as early as seven days from receipt of the application provided they are otherwise eligible.

(2) If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child will be denied.

c. For recipients, when changes occur, continuing eligibility will be redetermined according to 441—subrules 40.7(4) and 40.7(5).

d. A minor parent determined to have good cause for not living with a parent or legal guardian must attend the family development and self-sufficiency program or other family development as required in 441—subrule 93.4(4).

41.3(13) *Good cause for not living in the home of a parent or legal guardian.* Good cause exists when at least one of the following conditions applies:

a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.

b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following will be considered:

1. The present emotional state of the individual subject to emotional harm.

2. The emotional health history of the individual subject to emotional harm.

3. Intensity and probable duration of the emotional impairment.

c. The minor parent is in a foster care supervised apartment living arrangement.

d. The minor parent is participating in the job corps solo parent program.

e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department.

g. Other circumstances exist that indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations that appear to meet this good cause reason must be referred to the administrator of the division of adult, children and family services, or the administrator's designee, for determination of good cause.

41.3(14) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian will have the opportunity to claim good cause for not living with a parent or legal guardian.

41.3(15) *Determination of good cause for not living in the home of a parent or legal guardian.* The department will determine whether good cause exists for each applicant or recipient who claims good cause.

a. The applicant or recipient will be notified by the department of its determination that good cause does or does not exist. The determination will:

(1) Be in writing.

(2) Contain the department's findings and basis for determination.

(3) Be entered in the FIP case record.

b. When the department determines that good cause does not exist:

(1) The applicant or recipient will be so notified.

(2) The application will be denied or FIP assistance canceled.

c. The department will:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.3(16) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described in 441—subrule 40.4(1) and 441—paragraph 40.7(4) “c.”

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances that provide the basis for the good cause claim. Written statements from the client’s friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records that verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the department wishes to request additional corroborative evidence that is needed to permit a good cause determination, the department will:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.

(2) Specify the type of document that is needed.

c. When the applicant or recipient requests assistance in securing evidence, the department will:

(1) Advise the applicant or recipient how to obtain the necessary documents.

(2) Make a reasonable effort to obtain any specific documents that the applicant or recipient is not reasonably able to obtain without assistance.

441—41.4(239B) Home, residence, citizenship, and alienage.

41.4(1) *Iowa residence.*

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence will not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.4(2) *Suitability of home.* The home will be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

41.4(3) *Absence from the home.*

a. An individual who is absent from the home will not be included in the assistance unit, except as described in paragraph 41.4(3) “*b.*”

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.3(3). “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician’s statement. Failure to return within one year will result in the individual’s needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as described for children in paragraph 41.5(2) “*a*” and for adults in rule 441—93.8(239B), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs 41.4(3) “*b*”(1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual’s needs being removed from the grant.

41.4(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code sections 239B.2 and 239B.2B is eligible for participation in the FIP.

41.4(5) *Citizenship and alienage.*

a. Eligible status. An FIP assistance grant may include the needs of a citizen or national of the United States or a qualified alien as defined in rule 441—40.1(239B).

(1) A person who is a qualified alien as defined in rule 441—40.1(239B) is not eligible for FIP assistance for a five-year period beginning on the date of the person’s entry into the United States with a qualified alien status.

(2) Exceptions: The five-year prohibition from FIP assistance does not apply to:

1. A qualified alien residing in the United States before August 22, 1996.

2. A battered alien as described in subrule 41.4(4).

3. A qualified alien veteran who has an honorable discharge that is not due to alienage.

4. A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

5. A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in numbered paragraph 41.4(5) “*a*”(2)“3” or “4,” including a surviving spouse who has not remarried.

6. A refugee admitted under Section 207 of the Immigration and Nationality Act (INA).

7. An alien granted asylum under Section 208 of the INA.

8. An alien admitted as an Amerasian as described in 8 U.S.C. Section 1612(a)(2)(A)(ii)(V).

9. A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).

10. An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.

11. An alien certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

12. An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. Attestation of status. As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and recipients on an application form, a review form, or another attestation form prescribed by the department. A review form prescribed by the department may be used to attest to the citizenship of dependent children who enter a recipient household. Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligible group. The attestation may be signed by:

- (1) The applicant;
- (2) Someone acting responsibly on the applicant's or recipient's behalf if the applicant or recipient is incompetent or incapacitated; or
- (3) Any adult member of the assistance unit, when eligibility is determined on a family or household basis.

441—41.5(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. All persons in an FIP household will be referred to the PROMISE JOBS program and shall enter into a family investment agreement (FIA) as a condition of receiving FIP, unless exempt from referral, except as described in subrule 41.5(2).

41.5(1) FIA-responsible persons. The following persons are FIA-responsible unless the department determines the person is exempt:

- a.* All persons whose needs are included in a grant under the FIP program.
- b.* Any parent living in the home of a child receiving a grant.
- c.* All FIP applicants unless the department determines that the applicant is exempt or does not meet other FIP eligibility requirements.
- d.* Applicants who have chosen and are in an active limited benefit plan (LBP). FIA-responsible applicants in an active limited benefit plan shall complete significant contact with or action in regard to PROMISE JOBS as described in paragraphs 41.5(7)“*d*” and “*e*” for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent is exempt. Exceptions:

- (1) The applicant has become exempt from PROMISE JOBS.
- (2) The applicant is in a subsequent limited benefit plan and it is prior to the last day of the six-month period of ineligibility.

41.5(2) Exemptions. The following persons are exempt from referral:

- a.* A person who is under the age of 16 and is not a parent.
- b.* A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.
- c.* A person who is aged 16 to 19, is not a parent, and attends an elementary, secondary or equivalent level of vocational or technical school full-time. For persons who lose exempt status for not attending school, once the person has signed a family investment agreement, the person will remain referred to PROMISE JOBS and subject to the terms of the agreement.

(1) A person will be considered to be attending school full-time when enrolled or accepted in an elementary school, a secondary school, or the equivalent level of vocational or technical school or training leading to a certificate or diploma, and the school certifies the person's attendance as full-time. Enrollment in a correspondence school that gives instruction courses by mail is not an allowable program of study.

(2) A person will also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, an illness, a convalescence, or a family emergency.

(3) A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

d. A person who is not a United States citizen and is not a qualified alien as defined in 441—40.1(239B).

41.5(3) Parents aged 19 and under.

a. Unless exempt as described in subrule 41.5(2), parents aged 18 or 19 are referred to PROMISE JOBS as follows:

(1) A parent aged 18 or 19 who has not successfully completed a high school education (or its equivalent) will be required to participate in educational activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent will be required to participate in other PROMISE JOBS options if the person fails to make good progress in completing educational activities or if it is determined that participation in educational activities is inappropriate for the parent.

(3) The parent will be required to participate in parenting skills training in accordance with 441—Chapter 93.

b. Unless exempt as described in subrule 41.5(2), parents aged 17 or younger are referred to PROMISE JOBS as follows:

(1) A parent aged 17 or younger who has not successfully completed a high school education or its equivalent will be required to participate in high school completion activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent will be required to participate in parenting skills training in accordance with 441—Chapter 93.

41.5(4) Method of referral. The department will refer each FIA-responsible person as defined in subrule 41.5(1) to PROMISE JOBS to sign a family investment agreement.

a. *FIA-responsible applicants.* During the application interview, the department will notify the applicant of the requirement to sign a family investment agreement as a condition of FIP eligibility. The department will refer the applicant by scheduling the applicant for an appointment with the PROMISE JOBS provider agency to develop the family investment agreement.

(1) The appointment will be on the earliest available date but no later than ten calendar days from the date of referral unless the applicant requests an appointment on a day that is beyond ten calendar days. The PROMISE JOBS provider agency shall make sufficient appointment times available to allow the applicant to be scheduled within this time frame.

(2) The applicant will be notified verbally and in writing of the scheduled appointment. If the notice of a scheduled appointment is mailed to the applicant, the department will allow at least five working days from the date the notice is mailed for the applicant to appear for the scheduled appointment. The department may allow less than five working days if the applicant is verbally notified and agrees to the appointment.

(3) If a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department will deny FIP assistance for the entire family.

(4) If a minor parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department will deny FIP assistance for the minor parent and any child of the minor parent.

(5) If a referred person who is not a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department will deny FIP assistance only for that person.

b. *Hardship applicants.* While the eligibility decision is pending, unless the applicants are exempt from referral as defined in subrule 41.5(2), the department will refer applicants who must qualify for a hardship exemption before approval of FIP to PROMISE JOBS to sign a family investment agreement as described in paragraph 41.5(4)“a” and will treat applicants in accordance with subrule 41.11(3).

c. *Applicants in a limited benefit plan.* The department will refer FIA-responsible applicants to PROMISE JOBS as described in paragraph 41.5(4)“a” and inform the applicant of the actions needed to reconsider and end the limited benefit plan as described in subrule 41.5(7). Failure to appear for the

appointment without rescheduling or failure to sign a family investment agreement results in denial of the FIP application.

d. FIP participants who become FIA-responsible. When a person receiving FIP is no longer exempt, the department will send the FIP participant a notice. The notice will contain information about the requirement to sign a family investment agreement and will instruct the FIP participant to contact PROMISE JOBS within ten calendar days to schedule an appointment with PROMISE JOBS to develop a family investment agreement. If the participant fails to schedule or attend the appointment or fails to sign a family investment agreement, PROMISE JOBS will send a clear written reminder. After one written reminder as described in 441—paragraph 93.3(3) “b,” the participant will enter into a limited benefit plan as described in paragraph 41.5(8) “c.”

41.5(5) *Changes in status and redetermination of exempt status.* Any exempt person shall report any change affecting the exempt status to the department within ten days of the change. The department will reevaluate exempt persons when changes in status occur and at the time of six-month or annual review. The participant and the PROMISE JOBS unit will be notified of any change in a participant’s exempt status.

41.5(6) *Referral to vocational rehabilitation.* The department will make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.5(7) *LBP.* When a participant responsible for signing and meeting the terms of a family investment agreement chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant will enter into a limited benefit plan. A limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to the participant as defined in rules 441—16.1(17A) and 441—16.2(17A). Once the limited benefit plan is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose a limited benefit plan, the person who chose the limited benefit plan can reconsider and end the limited benefit plan, but only as described in paragraphs 41.5(8) “d” and “e.”

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of a first limited benefit plan, the FIP eligible group or individual participant shall not be eligible until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.5(8) “d.” If a subsequent limited benefit plan is chosen by the same participant, a six-month period of ineligibility applies to the FIP eligible group or individual participant and ineligibility continues after the six-month period is over until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.5(8) “e.” A limited benefit plan imposed in error as described in paragraph 41.5(8) “g” shall not be considered a limited benefit plan and shall not count when determining whether a household is subject to a subsequent limited benefit plan.

b. The limited benefit plan shall be applied to participants responsible for the family investment agreement and other members of the participant’s family as follows:

(1) When the participant responsible for the family investment agreement is a parent, the limited benefit plan shall apply to the entire FIP eligible group as defined in subrule 41.9(1).

(2) When the participant choosing a limited benefit plan is a needy specified relative or a dependent child’s stepparent who is in the FIP eligible group because of incapacity, the limited benefit plan shall apply only to the individual participant choosing the plan. Exception: The limited benefit plan shall apply to the entire FIP eligible group as defined in subrule 41.9(1) when a needy specified relative who assumes the role of parent was responsible for the family investment agreement and chose a limited benefit plan effective October 1, 2005, or earlier.

(3) When the FIP eligible group includes a minor parent living with the minor parent's adult parent or needy specified relative who receives FIP benefits and both the minor parent and the adult parent or needy specified relative are responsible for developing a family investment agreement, each parent or needy specified relative is responsible for a separate family investment agreement, and the limited benefit plan shall be applied as follows:

1. When the adult parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the entire eligible group, even though the minor parent has not chosen the limited benefit plan. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the family investment agreement process.

2. When the minor parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the minor parent and any child of the minor parent.

3. When the minor parent is the only eligible child in the adult parent's or needy specified relative's home and the minor parent chooses the limited benefit plan, the adult parent's or needy specified relative's FIP eligibility ceases in accordance with subrule 41.9(1). The adult parent or needy specified relative shall become ineligible beginning with the effective date of the minor parent's limited benefit plan.

4. When the needy specified relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply as described in subparagraph 41.5(8) "b"(2).

(4) When the FIP eligible group includes children who are FIA-responsible, the children shall not have a separate family investment agreement but shall be asked to sign the eligible group's family investment agreement and to carry out the responsibilities of that family investment agreement. A limited benefit plan shall be applied as follows:

1. When the parent or needy specified relative responsible for a family investment agreement meets those responsibilities but a child who is FIA-responsible chooses an individual limited benefit plan, the limited benefit plan shall apply only to the individual child choosing the plan.

2. When the child who chooses a limited benefit plan under numbered paragraph 41.5(8) "b"(4) "1" is the only child in the eligible group, the parents' or needy specified relative's eligibility ceases in accordance with subrule 41.9(1). The parents or needy specified relative shall become ineligible beginning with the effective date of the child's limited benefit plan.

(5) When the FIP eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are FIA-responsible, the children are responsible for completing a family investment agreement. If a child who is FIA-responsible chooses the limited benefit plan, the limited benefit plan shall be applied in the manner described in subparagraph 41.5(8) "b"(4).

(6) When both parents of an FIP child are in the home, a limited benefit plan shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for a family investment agreement and that parent chooses the limited benefit plan, the limited benefit plan applies to the entire family and cannot be ended by the voluntary participation in a family investment agreement by the exempt parent.

2. When both parents of a child in the eligible group are responsible for a family investment agreement, both are expected to sign the agreement. If either parent chooses the limited benefit plan, the limited benefit plan cannot be ended by the participation of the other parent in a family investment agreement.

3. When the parents from a two-parent family in a limited benefit plan separate, the limited benefit plan shall follow only the parent who chose the limited benefit plan and any children in the home of that parent.

4. A subsequent limited benefit plan applies when either parent in a two-parent family previously chose a limited benefit plan.

c. A participant shall be considered to have chosen a limited benefit plan under any of the following circumstances:

(1) A participant who loses exempt status and is referred to PROMISE JOBS as described in paragraph 41.5(4)“d” and who does not schedule or attend an appointment for orientation and development of a family investment agreement with PROMISE JOBS after PROMISE JOBS sends one clear written reminder as described in 441—paragraph 93.3(3)“b” shall enter into the limited benefit plan.

(2) A participant who chooses not to sign the family investment agreement shall enter into the limited benefit plan. For an applicant, signing a family investment agreement is an FIP eligibility requirement. If an applicant chooses not to sign the agreement, the limited benefit plan process is not applicable.

(3) A participant who signs a family investment agreement but does not carry out the family investment agreement responsibilities shall enter into a limited benefit plan whether the person signed the agreement as an FIP applicant or as an FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker’s request to renegotiate the family investment agreement when the participant has not attained self-sufficiency by the date established in the family investment agreement. A limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the family investment agreement.

d. Reconsideration of a first limited benefit plan. A person who chooses a first limited benefit plan may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. To reconsider and end the limited benefit plan, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the family investment agreement.

(1) Since a first limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition. To end the limited benefit plan, the person must also sign a family investment agreement, even if the person had signed an agreement before choosing the limited benefit plan.

(2) FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.6(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.2(5) when the family investment agreement is signed before the effective date of a first limited benefit plan.

e. Reconsideration of a subsequent limited benefit plan. A person who chooses a subsequent limited benefit plan may reconsider that choice at any time following the required six-month period of ineligibility.

(1) A subsequent limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to establish the limited benefit plan. Therefore, once timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition.

(2) FIP eligibility no longer exists as of the effective date of the limited benefit plan. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the limited benefit plan because the person is not eligible to sign a family investment agreement until the six-month period of ineligibility has expired.

(3) To reconsider and end the limited benefit plan, the person must:

1. Contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities,

2. Sign a new or updated family investment agreement, and

3. Satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service, unless problems as described in rule 441—93.14(239B) or barriers as described in 441—subrule 93.4(5) apply. The 20 hours of

employment or other activity must be completed within 30 days of the date that the family investment agreement is signed, unless problems as described in rule 441—93.14(239B) or barriers as described in 441—subrule 93.4(5) apply.

(4) FIP benefits shall not begin until the person who chose the limited benefit plan completes the previously defined significant actions. FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.6(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

f. Reconsideration by two-parent family. For a two-parent family when both parents are responsible for a family investment agreement as described in subrule 41.5(1), a first or subsequent limited benefit plan continues until both parents have completed significant contact or action with the PROMISE JOBS program as described in paragraphs 41.5(7) “*d*” and “*e*.”

g. Limited benefit plan imposed in error. A limited benefit plan imposed in error will not be considered a limited benefit plan. This includes any instance when participation in PROMISE JOBS should not have been required as described in the administrative rules. Examples of instances when an error has occurred are:

(1) The person was exempt from PROMISE JOBS participation at the time the person chose the limited benefit plan.

(2) It is verified that the person considered to have chosen the limited benefit plan moved out of state or requested cancellation of FIP prior to the date that PROMISE JOBS determined the limited benefit plan was chosen.

(3) The final appeal decision under 441—Chapter 7 reverses the decision to impose a limited benefit plan.

(4) It is determined that the entire amount of assistance issued for the person who chose the limited benefit plan is subject to recoupment for the month when the person chose not to fulfill the terms of the family investment agreement.

(5) The person informs PROMISE JOBS of a newly revealed problem as described in rule 441—93.14(239B) or barrier as described in 441—subrule 93.4(5) after the limited benefit plan is imposed, and it is reasonable that the problem or barrier contributed to a failure that resulted in imposition of the limited benefit plan. The person may be required to provide documentation of the problem or barrier as described in 441—subrule 93.10(3).

41.5(8) *Notification of services.*

a. The department will inform all applicants for and recipients of FIP of the advantages of employment under FIP.

b. The department will provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

c. The department will provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information will include explanations of child care assistance and transitional Medicaid.

d. The department will inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

e. The department will explain the LBP and the process by which FIA-responsible persons can choose the LBP.

f. The department will inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department will inform applicants for FIP benefits that a family investment agreement must be signed before FIP approval as a condition of eligibility, except as described in subrule 41.5(2).

441—41.6(239B) Uncategorized factors of eligibility.

41.6(1) *Duplication of assistance.* A recipient whose needs are included in an FIP grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care, state-funded foster care or kinship caregiver program payments.

a. A recipient shall not concurrently receive the FIP and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family.

b. When an FIP recipient is approved for foster care or subsidized adoption assistance while remaining in the same home, FIP assistance will be canceled effective the first day of the next calendar month following the date approval of the foster care or subsidized adoption payment is successfully entered into the department's computer system. FIP assistance for the month for which the foster care or subsidized adoption payment is approved or any past months for which foster care or subsidized adoption payments are made retroactively will not be subject to recoupment.

c. A recipient shall not concurrently receive a grant from a public assistance program in another state.

d. When a recipient leaves the home of a specified relative, no payment for a concurrent period will be made for the same recipient in the home of another relative.

41.6(2) *Aid from other funds.* Supplemental aid from any other agency or organization is limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance will be considered unearned income.

41.6(3) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the FIP when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.6(4) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living will be ineligible for the FIP for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual will be ineligible for the FIP for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

(2) An individual is not participating in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The income maintenance administrator will determine whether such a risk to the individual's physical or emotional well-being exists.

41.6(5) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.6(6) *Fugitive felons, and probation and parole violators.* Assistance will be denied to a person who is (1) convicted of a felony under state or federal law and is fleeing to avoid prosecution, custody or confinement, or (2) violating a condition of probation or parole imposed under state or federal law. The prohibition does not apply to conduct pardoned by the President of the United States, beginning with the month after the pardon is given.

41.6(7) *Access to benefits.* As a condition of eligibility, applicants and recipients must agree in writing to not use an electronic access card at prohibited locations. By signing an application or review form prescribed by the department, the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf agrees to this condition of eligibility. When both parents, or a parent and a stepparent, are in the

home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and agree to this condition for the assistance unit. Failure to sign a form agreeing to not use the electronic access card at prohibited locations creates ineligibility for the entire eligible group.

a. A recipient shall not use the recipient's electronic access card issued pursuant to 441—subrule 45.21(1) to access benefits at any of the following prohibited locations as defined by federal statute or regulation applicable to this prohibition and as further defined in rule 441—40.1(239B):

- (1) A liquor store,
- (2) A casino, gambling casino, or gaming establishment, or
- (3) A retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

b. When the department receives a detailed complaint or suspects that a recipient has used the recipient's electronic access card at a prohibited location, the case will be referred to the department of inspections, appeals, and licensing (DIAL) for further investigation.

c. When DIAL finds that a recipient has used the recipient's electronic access card at a prohibited location, the household that includes the recipient is:

- (1) Considered to have committed a fraudulent act;
- (2) Liable for any amounts accessed and any associated fees for accessing the benefits at a prohibited location and required to repay such amount in accordance with 441—Chapter 46;
- (3) Ineligible for FIP for a three-month period after the first report by DIAL that includes a finding of misuse;
- (4) Ineligible for FIP for a six-month period after each subsequent report by DIAL that includes a finding of misuse.

d. When parents from a two-parent family separate during an ineligibility period, if:

(1) DIAL identifies the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow that recipient.

(2) DIAL does not identify the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow the recipient who is the case name when the violation occurred.

e. A new period of ineligibility will be established when:

- (1) A recipient files an appeal either:
 1. Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or
 2. Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;
- (2) Assistance is continued pending the final decision of the appeal; and
- (3) The department's action is affirmed.

Assistance issued pending the final decision of an appeal is not subject to recovery pursuant to rule 441—7.17(17A).

441—41.7(239B) Resources.

41.7(1) Limitation. An applicant or recipient may have the following resources and be eligible for the FIP. Any resource not specifically exempted will be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter will be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished will not be considered to have altered the exempt status of the homestead. Except as described in paragraph 41.7(1)“*n*” or “*o*” and paragraph 41.7(6)“*c*,” the net market value of any other real property will be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, that are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance that has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of \$4,115 in one motor vehicle for each adult and working teenage child whose resources are considered as described in subrule 41.7(2). The disregard will be allowed when the working teenager is temporarily absent from work. The equity value in excess of \$4,115 of any vehicle will be counted toward the resource limit in paragraph 41.7(1)"*e.*" When a motor vehicle is modified with special equipment for the handicapped, the special equipment will not increase the value of the motor vehicle.

The department will annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for recipient assistance units. Exception: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the \$5,000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described in rules 441—45.6(239B) and 441—45.7(239B).

Resources of the applicant or the recipient will be determined in accordance with subrule 41.7(2).

f. Money that is counted as income in a month, during that same month; and that part of lump sum income defined in subparagraph 41.2(9)"*c*"(2) reserved for the current or future month's income.

g. Payments that are exempted for consideration as income and resources under subrule 41.8(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 will be counted toward resource limitations unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository that is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value that exceeds the exemption will be considered in computing whether the eligible group's property is within the reserve defined in paragraph 41.7(1)"*e.*"

o. Nonhomestead property that produces income consistent with the property's fair market value.

41.7(2) *Persons considered.*

a. Resources of persons in the eligible group will be considered in establishing property limitations.

b. Resources of the parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group will be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home will not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group will be considered in the same manner as a parent.

d. The resources of supplemental security income recipients will not be counted in establishing property limitations.

e. The resources of a nonparental relative who elects to be included in the eligible group will be considered in the same manner as a parent.

41.7(3) Homestead defined. The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it will not exceed ½-acre in area. When outside a city plat it will not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property will be determined in accordance with subrule 41.7(5).

41.7(4) Liquidation. When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements that are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 41.8(1) "b" and 41.8(7) "z." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

41.7(5) Net market value defined. Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

41.7(6) Availability.

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant/recipient owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. When property is owned by more than one person, unless otherwise established, it is assumed that all individuals hold equal shares in the property.

c. When the applicant or recipient owns nonhomestead property, the property will be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

41.7(7) Damage judgments and insurance settlements.

a. Payment resulting from damage to or destruction of an exempt resource will be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds will be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource will be considered a resource in the month following the month in which payment was received.

41.7(8) *Trusts.* The department will determine whether assets from a trust or conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the trust agreement or order establishing a conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance will be considered toward resource or income limitations.

b. When the department questions whether the funds in a trust or conservatorship are available, the trust or conservatorship will be referred to the central office.

(1) When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(2) Funds in a trust or conservatorship that are not clearly available will be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.7(9) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the resources of the alien will be deemed to include the resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the resources of the sponsor and the sponsor's spouse deemed to the alien will be the total countable resources as described in this rule remaining after a \$1,500 deduction is subtracted. The following are exceptions to deeming of a sponsor's resources:

a. Deeming of the sponsor's resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined in rule 441—40.1(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's resources for 12 months after indigence is determined. An alien will be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's resources for 12 months.

41.7(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment will not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and may include merchandise, grain held in storage, livestock raised for sale, and other unsold inventory. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets that, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, any inventory or supplies retained by the household will not be considered a resource.

441—41.8(239B) *Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, will be considered in determining initial and continuing eligibility and the amount of the FIP grant.

1. The determination of initial eligibility is a three-step process. Initial eligibility will be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the FIP grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group.

2. The determination of continuing eligibility is a two-step process. Continuing eligibility will be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group.

3. The amount of the FIP grant will be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.3(5) and retained by the department as described in subparagraph 41.8(1)"d"(2) will be considered as exempt income for the purpose of determining continuing eligibility. Deductions and diversions will be allowed when verification is provided.

41.8(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income will be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction will be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. When the applicant or recipient sells property on contract, proceeds from the sale will be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 41.7(4). The interest portion of the payment is considered a resource the month following the month of receipt.

c. Every person in the eligible group and any parent living in the home of a child in the eligible group will take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph 41.8(1)"c"(2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits will be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.8(2)"b."

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described in 441—subrule 40.7(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

d. Support payments in cash will be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, will be treated as unearned income and deducted from the initial assistance grant(s). Any cash support payment for a member of the eligible group, except as described in

paragraph 41.8(6)“p,” received by the recipient after the date of decision as defined in 441—subrule 40.4(3) will be refunded to child support services.

(2) Assigned support collected in a month and retained by child support recovery will be exempt as income for determining prospective or retrospective eligibility. Participants will have the option of withdrawing from FIP at any time and receiving their child support direct.

e. The applicant or recipient shall cooperate in supplying verification of all unearned income, as defined in 441—paragraph 40.4(1)“b” and 441—subrule 40.7(4). When the information is available, the department will verify unemployment insurance benefits by using information supplied to the department by the department of workforce development. When the client notifies the department that the amount of unemployment insurance benefits used is incorrect, the client will be allowed to verify the discrepancy. A payment adjustment will be made when indicated. Recoupment will be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision applicable to the payment month, whichever is later, in order to receive a payment adjustment.

41.8(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. Income will be considered earned income when it is produced as a result of the performance of services by an individual.

a. *Earned income deduction.* Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses will include all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. *Work incentive disregard.* After deducting the allowable work-related expenses as defined in paragraph 41.8(2)“a” and income diversions as defined in subrules 41.8(4) and 41.8(8), the department will disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income will be considered in determining eligibility and the amount of the assistance grant.

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility is determined without the application of the work incentive disregard as described in subparagraphs 41.8(9)“a”(2) and (3).

c. *Self-employment.* A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person’s own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

d. *Self-employment income.* Earned income from self-employment as defined in paragraph 41.8(2)“c” means the net profit from self-employment. “Net profit” means gross self-employment income less:

(1) Forty percent of the gross income to cover the costs of producing the income, or

(2) At the request of the applicant or recipient, actual expenses determined in the manner specified in paragraph 41.8(2)“e.”

e. *Deduction of self-employment expenses.* When the applicant or recipient requests that actual expenses be deducted, the net profit from self-employment income will be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent; the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

f. Child care income. Gross income from providing child care in the applicant's or recipient's own home will include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

g. Income verification. The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined in 441—paragraph 40.4(1)“b” and 441—subrule 40.7(4). A self-employed individual shall keep any records necessary to establish eligibility.

41.8(3) Shared living arrangements. When an FIP parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the FIP eligible group, exclusively for their needs, are considered income.

41.8(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent will be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.2(1). Income of the parent will be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within FIP standards. The maximum income that will be diverted to meet the needs of the ineligible child(ren) will be the difference between the needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in subparagraph 41.8(8)“a”(2) and paragraph 41.8(8)“b.”

b. Nonexempt earned and unearned income of the parent will be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

41.8(5) Income of unmarried specified relatives under age 19. Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent will be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the grant of the specified relative's parent will be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement will be treated in the same manner as though the specified relative had attained majority.

b. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents will be treated in accordance with subparagraphs 41.8(5) "b" (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative will be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative will be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) will be treated in accordance with paragraph 41.8(8) "c."

(3) When the unmarried specified relative is age 18, the income of the specified relative will be treated in the same manner as though the specified relative had attained majority.

41.8(6) *Exempt as income and resources.* The following will be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when utilized by the household for its own consumption.

b. The value of the supplemental nutrition assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined in subrule 41.3(1), conditional to school attendance, will be exempt.

However, any additional amount received for the person's dependents who are in the eligible group will be counted as nonexempt income.

s. Any income restricted by law or regulation that is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

t. The first \$50 received and retained by an applicant or recipient that represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case will the total amount exempted exceed \$50 per month per eligible group.

u. Bona fide loans. Evidence of a bona fide loan may include any of the following:

- (1) The loan is obtained from an institution or person engaged in the business of making loans.
- (2) There is a written agreement to repay the money within a specified time.
- (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

v. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

w. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, kinship caregiver program, or subsidized adoption assistance.

x. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

y. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "War-time Relocation of Civilians."

z. Payments received from the Radiation Exposure Compensation Act.

aa. Deposits into an IDA when determining eligibility and benefit amount. The amount of the deposit is exempt as income and will not be used in the 185 percent eligibility test. The deposit will be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client will be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in paragraphs 41.8(2)"a" and "c" will be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions will be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account will first be deducted from the client's nonexempt unearned income. Deposits will not be deducted from earned or unearned income that is exempt.

ab. Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.8(1)"d"(2).

41.8(7) Exempt as income. The following are exempt as income.

- a. Reimbursements from a third party.
- b. Reimbursement from the employer for job-related expenses.
- c. The following nonrecurring lump sum payments:
 - (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Foster care or kinship caregiver program payments received by the family that is:

(1) Providing foster care to a child or children when the family is operating a licensed foster home, or

(2) Caring for a relative or fictive kin child or children placed in the home by a court order.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the FIP, or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payment(s) from a passenger(s) in a car pool.

n. Support refunded by child support services for the first month of termination of eligibility and the family does not receive the FIP.

o. Income of a nonparental relative as defined in subrule 41.3(1) except when the relative is included in the eligible group.

p. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

q. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

r. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in paragraph 41.5(2) "c." The exemption applies through the entire month of the person's twentieth birthday.

Exception: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

s. Income attributed to an unmarried, underage parent in accordance with paragraph 41.8(8) "c" effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

t. Incentive payments received from participation in the adolescent pregnancy prevention programs.

u. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

v. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

w. Interest and dividend income.

x. Welfare reform and regular household honorarium income. All moneys paid to an FIP household in connection with the welfare reform demonstration longitudinal study or focus groups will be exempted.

y. Diversion or self-sufficiency grants assistance as described in 441—Chapter 47.

z. Payments from property sold under an installment contract as specified in paragraphs 41.7(4) “b” and 41.8(1) “b.”

aa. All census earnings received by temporary workers from the Bureau of the Census.

41.8(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. *Treatment of income in excluded parent cases.*

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described in paragraph 41.8(2) “a,” the work incentive disregard described in paragraph 41.8(2) “b,” and diversions described in subrule 41.8(4).

(2) The excluded parent will be permitted to retain that part of the parent’s income to meet the parent’s needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described in subrule 41.8(11).

(3) All remaining income of the excluded parent will be applied against the needs of the eligible group.

b. *Treatment of income in stepparent cases.* The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), will be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs 41.8(8) “b”(1) through (9).

(1) The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, will receive a 20 percent earned income deduction.

(2) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, will be deducted from nonexempt monthly earned and unearned income of the stepparent.

(3) The stepparent will also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(4) Except as described in subrule 41.8(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in subparagraphs 41.8(8) “b”(1) through (4) will be used to meet the needs of the stepparent and the stepparent’s dependents living in the home, when the dependents’ needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs will be determined in accordance with the FIP standard of need for a family group of the same composition.

(5) The stepparent will be allowed the work incentive disregard described in paragraph 41.8(2) “b” from monthly earnings. The disregard will be applied to earnings that remain after all other deductions in subparagraphs 41.8(8) “b”(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described in subparagraphs 41.8(9) “a”(2) and (3).

(6) The deductions described in subparagraphs 41.8(8) “b”(1) through (6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs 41.8(8) “b”(3) through (5) will be subtracted from unearned income. Any remaining income will be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income will be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(7) A nonexempt nonrecurring lump sum received by a stepparent will be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt will be considered a resource to the stepparent.

(8) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described in subrule 41.8(11).

(9) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP will be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, will be considered a separate unit.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parent(s), the income of each self-supporting parent will be considered available to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 41.8(8)“b”(1) through (7). Nonrecurring lump sum income received by the self-supporting parent(s) will be treated in accordance with subparagraph 41.8(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse will be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 41.8(8)“b”(1) to (7). Nonrecurring lump sum income received by the spouse of the self-supporting parent will be treated in accordance with subparagraph 41.8(8)“b”(8). The self-supporting parent and any ineligible dependents of that person will be considered as one unit; the self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, will be considered a separate unit.

41.8(9) Budgeting process. Both initial and ongoing eligibility and benefits will be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made will be considered to determine eligibility for the FIP, except income that is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview will be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with subparagraph 41.8(9)“c”(1) and paragraph 41.8(9)“i,” the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision will be deducted from earned income, except when determining eligibility under the 185 percent test defined in rule 441—41.8(239B). The determination of eligibility in the month of decision is a three-step process as described in rule 441—41.8(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application will be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in 441—41.8(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need will then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as

specified in paragraph 41.8(2) “b.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application will be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.8(2) “b” will be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application will be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the FIP grant will be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.8(9) “a”(4).

(4) Eligibility for the FIP for any month or partial month before the month of decision will be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision will be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family composition in that month will be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described in subrule 41.11(1), FIP eligibility will be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

b. Ongoing eligibility.

(1) The department will prospectively compute eligibility and benefits when review information is submitted as described in 441—subrule 40.7(3). All countable earned and unearned income received by the eligible group during the previous 30 days will be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the department will prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) The earned income deduction for each wage earner as defined in paragraph 41.8(2) “a” and the work incentive disregard as defined in paragraph 41.8(2) “b” will be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, will be considered as income in the month received. Income received by an individual employed under a contract will be prorated over the period of the contract. Income received at periodic intervals or intermittently will be considered as income in the month received, except periodic or intermittent income from self-employment will be treated as described in paragraph 41.8(9) “i.” When the income that is subject to proration is earned, appropriate disregards, deductions and diversions will be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.7(4) and 41.7(7) and paragraphs 41.8(8) “b” and 41.8(8) “c,” will be treated in accordance with this rule. Nonrecurring lump-sum income will be considered as income in the month received and counted in computing eligibility and the amount of the grant, unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit,

a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the FIP grant but including countable lump-sum income, exceeds the needs of the eligible group, the case will be canceled or the application rejected. In addition, the eligible group will be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation will be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility will begin with the month the lump sum is received.

1. When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.7(4) “f,” recoupment will not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by 441—16.2(17A) requires that the action be delayed until the second calendar month following the month of change, recoupment will not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment will be made beginning with the month of receipt.

2. The period of ineligibility will be shortened when the schedule of living costs as defined in subrule 41.9(2) increases.

3. The period of ineligibility will be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

4. The period of ineligibility will also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 41.7(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

5. When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum will be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the FIP as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home will be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment will be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.3(4) “f.”

e. In any month for which an individual is determined eligible to be added to a currently active FIP case, the individual's needs will be included subject to the effective date of grant limitations as prescribed in rule 441—40.6(239B).

(1) When adding an individual to an existing eligible group, any income of that individual will be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group will be removed prospectively effective the first of the following month.

f. When income received weekly or biweekly (once every two weeks) is projected for future months, it will be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result will be multiplied by four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

g. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis will be budgeted in the same manner as the earnings of an employee. The countable income will be the net income.

h. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income will be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment will be handled in accordance with subparagraphs 41.8(9) "i"(3), (4), and (5).

(1) When a self-employment enterprise that does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income will be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker will establish, with the cooperation of the client, a reasonable estimate that will be considered accurate and projected for three months, after which the income will be averaged and projected for the same period of time. Any changes in self-employment will be considered in accordance with subparagraphs 41.8(9) "i"(3), (4) and (5).

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department will recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses will be computed on the basis of the change.

i. Special needs.

(1) A special need as defined in subrule 41.9(3) must be documented before payment will be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment will be included, prospectively, in each month's FIP grant. When the special need ends, payment will be removed prospectively. Any overpayment for a special need will be recouped.

j. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the FIP as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home will be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person will be considered prospectively in accordance with subrules 41.8(4) and 41.8(8).

41.8(10) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income of the alien will be deemed to include the income of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the income of the sponsor and the sponsor's spouse deemed to the alien will be the total gross earned and unearned income remaining after allowing the earned income deduction described in paragraph 41.8(2) "a," the work incentive disregard described in paragraph 41.8(2) "b," and diversions described in subrule 41.8(4). The following are exceptions to deeming of a sponsor's income:

a. Deeming of the sponsor's income does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined in rule 441—40.1(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's income for 12 months after indigence is determined. An alien will be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income for 12 months.

41.8(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.5(7) or 41.6(4), or who has been disqualified under subrule 41.6(6) or rule 441—46.7(239B), or who is required to be included in the eligible group according to paragraph 41.9(1) "a" and has failed to cooperate. This restriction applies to paragraph 41.8(4) "a" and subrule 41.8(8).

441—41.9(239B) Need standards.

41.9(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act. There will be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons will be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on a form prescribed by the department. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on a form prescribed by the department. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

41.9(2) *Schedule of needs.* The schedule of living costs represents 100 percent of basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the standard of need defined in rule 441—40.1(239B). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—41.8(239B). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in and are eligible for an FIP grant. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the assistance grant, when these needs must be determined in accordance with the payment standard defined in rule 441—40.1(239B). The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below.

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communi-cations	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transpor-tation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
- (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
- (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
- (4) Food: Including school lunches.
- (5) Clothing: Including layette, laundry, dry cleaning.
- (6) Personal care and supplies: Including regular school supplies.
- (7) Medicine chest items.

- (8) Communications: Telephone, newspapers, magazines.
- (9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home will be considered a separate eligible group when the relative is receiving the FIP assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the FIP, the needs of the specified relative, when eligible, will be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker will be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker will be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the FIP but the specified relative is not an eligible child, need of the specified relative will be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need will be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the FIP, the needs of the specified relative, when eligible, will be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in subrule 41.3(1), only the needs of the eligible children will be included in the assistance grant. When the unmarried specified relative is aged 18, need will be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources will not be considered in determining FIP benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant will be computed on the basis of their comprising one eligible group. This rule is not intended to mandate that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.9(3) *Special needs.* On the basis of demonstrated need the following special needs will be allowed, in addition to the basic needs.

a. School expenses. Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, will be allowed provided the allowance will not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. Guardian/conservator fee. An amount not to exceed \$10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

441—41.10(239B) Composite FIP/SSI cases. When persons in the FIP household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following subrules will apply:

41.10(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the FIP grant pending approval of supplemental security income.

41.10(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the FIP recipient, each will be considered as having a half interest in order to

determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

441—41.11(239B) Time limits.

41.11(1) *Sixty-month limit.* Assistance will not be provided to an FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or under any program in another state that is funded by the federal Temporary Assistance for Needy Families (TANF) block grant unless the applicant or recipient family is eligible for a hardship as defined in subrule 41.11(3). The 60-month period need not be consecutive. In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

a. An “adult” is any person who is a parent of the FIP child in the home, the parent’s spouse, or included as an optional member under subparagraph 41.9(1) “b”(1) or (2).

b. “Assistance,” for the purpose of this rule, will include any month for which the adult receives an FIP grant or a payment in another state using federal TANF funds that the other state deems countable toward the 60-month federal limit. Assistance received for a partial month will count as a full month.

41.11(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department will consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are SSI recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.9(1) “b”(1) and (2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described in subparagraph 41.9(1) “b”(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent’s case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department will not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.6(239B) and 441—45.7(239B).

e. The department will not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent’s or the specified relative’s FIP case.

f. The department will not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 United States Code Section 1151) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.11(3) *Exception to the 60-month limit.* A family may receive FIP assistance for more than 60 months as defined in subrule 41.11(1) if the family qualifies for a hardship exemption as described in this subrule. “Hardship” is defined as a circumstance that is preventing the family from being self-supporting. However, the family’s safety will take precedence over the goal of self-sufficiency.

a. Eligibility determination. Eligibility for the hardship exemption will be determined on an individual family basis. A hardship exemption will not begin until the adult in the family has received at least 60 months of FIP assistance.

b. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include the following:

(1) Domestic violence. “Domestic violence” means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.
2. Sexual abuse.
3. Sexual activity involving a dependent child.
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.

5. Threats of, or attempts at, physical or sexual abuse.

6. Mental abuse.

7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.4(5).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient will follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance use disorder. A family requesting a hardship exemption due to substance use disorder will be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include but is not limited to a child as defined in rule 441—170.1(237A) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child will take precedence over the goal of self-sufficiency.

(8) Other circumstances that prevent the family from being self-supporting.

c. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family’s current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family’s ability to leave FIP rather than the type of circumstances.

(2) Families with FIA-responsible persons who are not exempt from referral as defined in subrule 41.5(2) determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that an FIA-responsible person who is not exempt as defined in subrule 41.5(2) has that were known and existing before the family reached the 60-month limit will not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

d. Requesting a hardship exemption.

(1) Families that have or are close to having received 60 months of assistance as defined in subrule 41.11(1) may request a hardship exemption. Requests for the hardship exemption shall be made on a hardship request form prescribed by the department. In addition, families that have received assistance for 60 months and are no longer receiving FIP shall complete an application form prescribed by the department as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department’s request will result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.11(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption will not be accepted prior to the first day of the family's fifty-ninth month of assistance. The date of the request will be the date an identifiable hardship request form prescribed by the department is received in any department or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.11(1) who has received assistance for 60 months joins a recipient family that has not received 60 months of assistance, eligibility will continue only if the recipient family submits a hardship request form prescribed by the department and is approved for a hardship exemption as described in subrule 41.11(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.11(1) joins a recipient family that is in an exemption period, the current exemption period will continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, will follow the parent who retains the current FIP case.

e. Determination of hardship exemption.

(1) A determination on the request will be made as soon as possible, but no later than 30 days following the date an identifiable hardship request form prescribed by the department is received in any department or PROMISE JOBS office. A written notice of decision will be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption. The 30-day time standard will apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.5(239B) will apply.

(3) Income maintenance will determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department will advise the applicant or recipient about how to obtain necessary documents. Upon request, the department will provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter will not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department will notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family will be

allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.4(1) or 441—paragraph 40.7(4)“c.” Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, will result in denial of the family’s request for a hardship exemption.

(7) Recipients whose FIP assistance is canceled at the end of the sixtieth month will be eligible for reinstatement as described in 441—subrule 40.2(5) when a hardship request form prescribed by the department is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(8) When a hardship request form prescribed by the department is not received before the effective date of the FIP cancellation and a Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance will be no earlier than seven days from the date of application as described in rule 441—40.6(239B).

(9) Eligibility for a hardship exemption will last for six consecutive calendar months. Exception: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new hardship request form prescribed by the department. A new hardship exemption determination will be required prior to FIP approval.

(10) FIP received for a partial month of the six-month hardship exemption period will count as a full month.

(11) There is no limit on the number of hardship exemptions a family may receive over time.

f. Six-month FIA. Families who request a hardship exemption shall develop and sign a six-month FIA as defined in 441—93.4(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.11(1) shall sign the six-month FIA unless the adult is a stepparent and is not requesting assistance or is exempt as specified at subrule 41.5(2).

(1) The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption will require a new six-month FIA. Failure to develop or sign a six-month FIA will result in denial of the family’s hardship exemption request.

(2) Families that request a hardship exemption will be notified verbally and will be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days will be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(3) Failure to attend a scheduled interview when required, except for reasons beyond the adult’s control, will result in a denial of the family’s hardship exemption request. In two-parent families, both parents will be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult’s behalf may participate in the interview.

(4) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family to monitor progress. These contacts need not be in person. Time and attendance reports shall be required as specified in 441—subrule 93.10(2).

(5) The six-month FIA shall be renegotiated and amended under the circumstances described in 441—subrule 93.4(8).

(6) Any family that is not exempt from referral as defined in subrule 41.5(2), that has been granted a hardship exemption, and that does not follow the terms of the family’s six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapter 41 and 441—Chapter 93.

g. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 239B.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 43
“Alternate Payees”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 239B.4(6)
State or federal law(s) implemented by the rulemaking: Iowa Code section 239B.13

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

Currently this chapter outlines payments to the conservator, guardian or emergency payee of a child. This chapter is proposed to be rescinded.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.

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:

There are only two rules with content in this chapter (beyond those in reserved status). These two rules with content have been moved and will continue to exist in 441—Chapter 40. Because the substance of this chapter will continue to remain present in 441—Chapter 40, no impacts were identified.

- Qualitative description of impact:
See above.

3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **441—Chapter 43.**

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 45
“Payment”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 239B.4(6)
State or federal law(s) implemented by the rulemaking: Iowa Code sections 239B.2, 239B.3, and 239B.7

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter defines how Family Investment Program (FIP) payments are issued, how to handle underpayments, the limit on payments, and rounding of the standard of need and payment amount.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Persons receiving payments under FIP will benefit.
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:
For state fiscal year 2023, there were approximately 11,011 clients on average per month enrolled in FIP.
 - Qualitative description of impact:
These rules play an important role in providing precise procedure and a legal basis for decisions made by the Department.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

The Department incurs personnel costs to implement the program.

- Anticipated effect on state revenues:

There are no additional costs beyond those already appropriated.

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

If this chapter did not exist, there would be a lack of clear guidance and legal authority for FIP payment decisions.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

None.

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

Some of the benefit can be achieved through employee manuals. However, additional structure is needed to provide precise procedure and a legal basis for decisions made by the Department.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 45 and adopt the following **new** chapter in lieu thereof:

CHAPTER 45 PAYMENT

441—45.1(239B) Issuing payment. The department may issue assistance payments pursuant to Iowa Code section 239B.3(3).

45.1(1) Electronic access card. The department will make payments available through an electronic access card issued to the payee except when:

- a. The recipient requests direct deposit; or
- b. The department determines it is not practicable to issue the payment by electronic access card.

45.1(2) *Direct deposit.* The department will issue payments by direct deposit to the recipient's own account in a financial institution if the recipient completes a form prescribed by the department to request direct deposit.

45.1(3) *Warrant.* The department will issue payments by warrant when the recipient has not requested direct deposit and the department determines it is not practicable to issue payment by electronic access card. These circumstances include but are not limited to the following:

- a.* A one-time payment is issued.
- b.* The payee is a representative payee, conservator, or guardian who is not part of the FIP assistance unit.
- c.* The payee is unable to provide a social security number or an individual taxpayer identification number.

441—45.2(239B) *Return.* Assistance warrants cannot be forwarded. When warrants cannot be delivered by the post office, they shall be returned to the department.

441—45.3(239B) *Held warrants.* A warrant may be held by the department only in the following instances:

- 45.3(1)** The recipient's whereabouts is unknown.
- 45.3(2)** The recipient is not in the home due to an emergency and it is not known who will be serving as emergency payee.

441—45.4(239B) *Underpayment.* A corrective payment will be made when the recipient receives a payment in an amount less than that for which the recipient was eligible due to an administrative or client error or the recipient reports the completion of the federal tax return requiring repayment to Internal Revenue Service of excess advance earned income credit payments received in the prior calendar year.

45.4(1) *Attribution of underpayments.*

a. An underpayment may be attributed to the department as a result of one of the following circumstances:

- (1) Misfiling or loss of forms or documents.
- (2) Errors in typing or copying.
- (3) Computer input errors.
- (4) Mathematical errors.
- (5) Failure to certify assistance in the correct amount when all essential information was available to the department.
- (6) Failure to make prompt revisions in grants following changes in policies requiring the changes as of a specific date.

b. An underpayment may be attributed to the client as a result of one of the following circumstances:

- (1) Information reported in error, oral or written, regarding the client's income, resources, or other circumstances that may affect eligibility or the amount of assistance received.
- (2) Failure to timely report changes in income, resources, or other circumstances that may affect eligibility or the amount of assistance received.

45.4(2) *Conditions under which a retroactive corrective payment may be made.*

- a.* Retroactive corrective payments will be made for all underpayments.
- b.* Any retroactive corrective payment for which the recipient is eligible will first be applied to any unpaid overpayment before the balance, if any, is paid to the recipient.
- c.* Retroactive corrective payments will be made for underpayments discovered on and after October 1, 1981, regardless of when the underpayment occurred. Recipients and former applicants and recipients are responsible for supplying any information needed to determine the amount of an underpayment.

45.4(3) The amount of the corrective payment to the recipient for repayment to Internal Revenue Service of excess advance earned income credit payments will be computed on the basis of the earnings considered in determining the family investment program grant for the prior year.

45.4(4) A retroactive corrective payment is:

- a.* Exempt from consideration as income.
- b.* Exempt from consideration as a resource in the month received and the following month.

441—45.5(239B) Deceased payees. A retroactive corrective payment will be made for deceased payees only when the payment was approved by the department before the recipient's death. Payment for a special need will be made only when the payment is entered on the automated benefit calculation system before the effective date of cancellation.

441—45.6(239B) Limitation on payment. A payment will be made to an eligible recipient only when the amount of the assistance is \$10 or more.

441—45.7(239B) Rounding of need standard and payment amount. The need standard and monthly payment amount will be rounded down to the next whole dollar when the result of determining the standard of need or the payment amount is not a whole dollar.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, and 239B.7.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 46
“Overpayment Recovery”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 239B.4(6)

State or federal law(s) implemented by the rulemaking: Iowa Code sections 239B.2, 239B.3, 239B.7, and 239B.14

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The proposed chapter outlines what an overpayment is, how repayment of an overpayment can be made, and the procedure for recoupments.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Those interested in a fair and equitable program will benefit.
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:
For state fiscal year 2023, \$235,773 was collected for Family Investment Program (FIP) overpayments.
 - Qualitative description of impact:
These proposed rules play an important role in providing a framework needed to provide clarity and a legal basis for decisions made by the Department.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
The Department incurs personnel costs to implement the program.

- Anticipated effect on state revenues:

There are no additional costs beyond those already appropriated.

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

If this chapter did not exist, there would be no standard for what an overpayment is, how repayment of an overpayment can be made, and the procedure for recoupments. This would cause this process to be inconsistent.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

None.

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

Some of the benefit can be achieved through forms prescribed by the Department and internal documents. However, additional framework is needed to provide clarity and a legal basis for decisions made by the Department.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 46 and adopt the following **new** chapter in lieu thereof:

CHAPTER 46 OVERPAYMENT RECOVERY

441—46.1(239B) Definitions.

“Agency error” in overpayments means:

1. The same circumstances as described in 441—subrule 45.4(1) pertaining to underpayments, or
2. Any error that is not a client or procedural error.

“Client” means a current or former applicant or recipient of the family investment program.

“Client error” means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances that may affect eligibility or the amount of assistance received;

2. Failure to timely report changes in income, resources, or other circumstances as required by rule 441—40.7(239B);

3. Failure to refund to child support services any nonexempt payment from the absent parent received after the date the decision on eligibility was made; or

4. Access of benefits issued via the electronic access card at a prohibited location pursuant to subrule 41.6(7).

“*Overpayment*” means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive or the amount of any payment accessed and any associated fees for accessing the benefits at a prohibited location pursuant to subrule 41.6(7).

“*Procedural error*” means a technical error that does not in and of itself result in an overpayment. Procedural errors include:

1. Failure to secure a properly signed application at the time of initial application or reapplication.

2. Failure to secure a properly signed form prescribed by the department to request FIP beyond 60 months as described in 441—subrule 41.11(3).

3. Failure of the department to conduct the interviews described in 441—subrules 40.4(2) and 40.7(1).

4. Failure to request a review form prescribed by the department at the time of a semiannual or annual review.

5. Failure of department staff to cancel the family investment program benefits when the client submits a review form prescribed by the department that is not complete as defined in 441—paragraph 40.7(4) “b.” However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

“*Recoup*” means reimburse, return, or repay an overpayment.

“*Recoupment*” means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

441—46.2(239B) Monetary standards.

46.2(1) *Amount subject to recoupment.* All family investment program overpayments will be subject to recoupment.

46.2(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued will be for no less than \$10.

441—46.3(239B) Notification and appeals. All clients will be notified by the department of inspections, appeals, and licensing, as described in 441—paragraph 7.4(3) “i,” when it is determined that an overpayment exists. Notification will include the amount, date and reason for the overpayment. The department will provide additional information regarding the computation of the overpayment upon the client’s request. The client may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—paragraph 7.4(3) “i.”

441—46.4(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision will be recouped. A procedural error alone does not result in an overpayment.

46.4(1) *Agency error.* When an overpayment is due to an agency error, recoupment will be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.3(4) or 41.3(5) from being met or when the client receives a duplicate grant.

a. An overpayment of any amount is subject to recoupment with one exception: when the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment will be made only when the amount received exceeds the amount on the notice by \$10 or more.

b. An overpayment due to agency error will be computed as if the information had been acted upon timely.

46.4(2) *Assistance paid pending appeal decision.* Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing will begin no later than the month after the month in which the final decision is issued.

46.4(3) *Client error.*

a. An overpayment due to client error will be computed as if the information had been reported and acted upon timely.

b. Overpayments due to failure to refund payments received from the absent parent will be the total nonexempt support payment made for members of the eligible group at the time the support payment was received. In addition, assistance payments made to meet the needs of the eligible group may also be subject to recoupment under provisions in 441—subrule 41.3(4).

c. An overpayment due to a recipient's accessing benefits via the electronic access card at a prohibited location will be the total of the transactions and any associated fees for accessing the benefits at the prohibited location pursuant to 441—subrule 41.6(7).

46.4(4) *Failure to cooperate.* Failure to cooperate in the investigation of alleged overpayments will result in ineligibility for the months in question and the overpayment will be the total amount of assistance received during those months.

441—46.5(239B) Source of recoupment. Recoupment will be made from basic needs. The minimum recoupment amount will be the amount prescribed in subrule 46.5(1). Regardless of the source, the client may choose to make a lump sum payment, make periodic installment payments when an agreement to do this is made with the department of inspections, appeals, and licensing, or have repayment withheld from the grant. The client shall sign a form prescribed by the department when requested to do so by the department of inspections, appeals, and licensing. When the client fails to make the agreed upon payment, the agency will reduce the grant.

46.5(1) *Basic needs.*

a. Recoupment by withholding from basic needs for overpayments due to client error or a combination of client and agency errors will be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.9(2).

b. Recoupment by withholding from basic needs for overpayments due to the continuation of benefits pending a decision on an appeal as provided under 441—Chapter 7 or a combination of continued benefits and agency or client errors will be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.9(2).

c. Recoupment by withholding from basic needs for overpayments due to agency error will be 1 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.9(2).

46.5(2) Reserved.

441—46.6(239B) Procedures for recoupment.

46.6(1) *Referral.* When the department determines that an overpayment exists, the case will be referred to the department of inspections, appeals, and licensing for investigation, recoupment, or referral for possible prosecution.

46.6(2) *Change of circumstances.* When financial circumstances change, any agreement to pay a debt is subject to revision.

46.6(3) *Collection.* Recoupment for overpayments will be made from the parent or nonparental relative who was the caretaker relative, as defined in 441—subrule 41.3(1), at the time the overpayment occurred. When both parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

46.6(4) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the case is canceled and the amount of the overpayment is less than \$35. If the case is reopened within three years, recoupment is initiated again. Recoupment will be waived on nonfraud overpayments of less than \$35 that have been held in suspense for three years.

441—46.7(239B) Fraudulent misrepresentation of residence. A person convicted in a state or federal court, or in an administrative hearing, of having made a fraudulent statement or representation of the person's place of residence in order to receive assistance simultaneously from two or more states will be ineligible for assistance for ten years. For the purpose of this rule, the term "assistance" means assistance under Titles IV-A or XIX of the Social Security Act, or the Food Stamp Act of 1977, or benefits in two or more states under the Supplemental Security Income program under Title XVI. The ten-year period begins on the date the person is convicted. The prohibition does not apply to a convicted person who is pardoned by the President of the United States, beginning with the month after the pardon is given.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.7, and 239B.14.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 47
“Diversion Initiatives”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 239B.4(6)

State or federal law(s) implemented by the rulemaking: Iowa Code sections 234.6 and 239B.11

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50310
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of the Family Self-Sufficiency Grants (FSSG) program is to provide immediate and short-term assistance to PROMISE JOBS participant families, which will remove barriers related to obtaining or retaining employment.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Families participating in the PROMISE JOBS program seeking self-sufficiency will benefit.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
In state fiscal year 2023, FSSG made 1,554 payments to 812 families and the total expended was \$570,285.17. FSSG spent 49.1 percent of what was allotted.
 - Qualitative description of impact:
These rules play an important role in the implementation of the FSSG program. Without this chapter, there would be no way to implement the FSSG program and leave appeal rights intact for participants.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

The Department and the Iowa Workforce Development Department incur personnel costs to implement the program.

- Anticipated effect on state revenues:

There are no additional costs beyond those already appropriated.

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

Families participating in PROMISE JOBS would be less successful without access to the flexible funding that FSSG can provide to them. The goal of the FSSG program is to reduce the length of time a family is dependent on the Family Investment Program.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

None.

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

Without this chapter, there would be no way to implement the FSSG program and leave appeal rights intact for participants.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 47 and adopt the following **new** chapter in lieu thereof:

CHAPTER 47 DIVERSION INITIATIVES

441—47.1(239B) Definitions.

“*Appropriate responsible administrator*” means the administrator of the department of workforce development’s division of workforce development center administration, or the administrator’s designee.

“*Candidate*” means anyone expressing an interest in the family self-sufficiency grants program.

“*Family*” means “assistance unit” as defined in rule 441—40.1(239B).

“Family investment program” or *“FIP”* means the cash grant program provided by 441—Chapters 40 and 41, designed to sustain Iowa families.

“Family self-sufficiency grants” or *“FSSG”* means the payments made to specific PROMISE JOBS participants, to vendors on behalf of specific PROMISE JOBS participants, or for services to specific PROMISE JOBS participants.

“Immediate, short-term assistance” means that assistance provided under this chapter will be authorized upon determination of need and that it will not occur on a regular basis.

“Iowa workforce development” or *“IWD”* means the agency that develops and administers employment, placement and training services in Iowa and is contracted by the department to administer PROMISE JOBS services statewide.

“IWD service delivery area” means the Iowa workforce development service delivery areas designated to provide PROMISE JOBS services.

“Local plan for family self-sufficiency grants” means the written policies and procedures for administering the grants for families as set forth in the plan developed by the PROMISE JOBS IWD service delivery area as described in rule 441—47.6(239B).

“Participant” means anyone receiving assistance under this chapter.

“PROMISE JOBS contract” means the agreement between the department and Iowa workforce development regarding delivery of PROMISE JOBS services.

“PROMISE JOBS participant” means any person receiving services through PROMISE JOBS. A PROMISE JOBS participant must be a member of an eligible FIP household.

“Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program” means the department’s work and training program as described in 441—Chapter 93.

441—47.2(239B) Availability of the family self-sufficiency grants program. The family self-sufficiency grants program will be available statewide.

47.2(1) The program will be available for use by the IWD service delivery areas. Under the PROMISE JOBS contract, IWD shall allocate the funds available for authorization to each of the service delivery areas based on the allocation standards used for PROMISE JOBS service delivery purposes.

47.2(2) The department retains the funds that are released through the PROMISE JOBS expense allowance authorization system.

441—47.3(239B) General criteria. Family self-sufficiency grants candidates shall be PROMISE JOBS participants. Participation in the family self-sufficiency grants program is voluntary and will be based on an informed decision by the family. Further, candidates must have identifiable barriers to obtaining or retaining employment that can be substantially addressed through the assistance offered by family self-sufficiency grants.

441—47.4(239B) Assistance available in family self-sufficiency grants. Family self-sufficiency grants will be authorized for removing an identified barrier to self-sufficiency when it can be reasonably anticipated that the assistance will enable PROMISE JOBS participant families to obtain or retain employment in the two full calendar months following the date of authorization of payment. For example, if a payment is authorized on August 20, it should be anticipated that the participant can find employment in September or October.

47.4(1) *Employment does not occur.* If employment does not occur in the anticipated two-calendar-month period or if the participant loses employment in spite of the self-sufficiency grant, no penalty is incurred and no overpayment has occurred.

47.4(2) *Types of assistance.* The department, in conjunction with IWD, will determine those barriers to self-sufficiency that can be considered for family self-sufficiency grants such as, but not limited to, auto maintenance or repair, licensing fees, child care, and referral to other resources,

including those necessary to address questions of domestic violence. The IWD service delivery areas will have the opportunity to adjust the list of approvable barriers to self-sufficiency based on local resources and circumstances. These adjustments will be approved by the department and the appropriate responsible administrator prior to implementation.

47.4(3) *Limit on assistance.* The total payment limit per FIA-responsible person is \$1,000 per year. A year for a family will be the 12 fiscal months following the date of authorization of the initial payment for the family. A fiscal month begins and ends in different calendar months.

47.4(4) *Frequency of assistance.* Family self-sufficiency grants are intended to provide immediate and short-term assistance and must meet the criteria in this rule. While a family may be a candidate more than once and may receive payments in consecutive months in some circumstances, payments will not be established as regular or ongoing.

47.4(5) *Supplanting.* Family self-sufficiency grants will not be used for services already available through the department, PROMISE JOBS, or other local resources at no cost.

47.4(6) *Relationship to the family investment agreement.* Family self-sufficiency grants are separate from the PROMISE JOBS family investment agreement process. While the family investment agreement must be honored at all times and renegotiated and amended if family circumstances require it, no family will be considered to be choosing the limited benefit plan if the family chooses not to participate in the family self-sufficiency grant program.

47.4(7) *Issuing payments.* Family self-sufficiency grants are PROMISE JOBS benefits and will be authorized through the PROMISE JOBS expense allowance system. Payments may be issued to the participants or to a vendor for support services provided to the family. The department in conjunction with the appropriate responsible administrator will have discretion in determining method of payment. The IWD service delivery area will have the opportunity to adjust these payment options in an individual case based on circumstances and needs of the family with the approval of the department and the appropriate responsible administrator prior to implementation.

441—47.5(239B) Application, notification, and appeals.

47.5(1) *Application elements.* Each IWD service delivery area shall use the established application form to be completed by the PROMISE JOBS participant and the PROMISE JOBS worker when the participant asks to be a candidate for a family self-sufficiency grant. The application form must contain the following elements:

- a. An explanation of family self-sufficiency grants and the expectations of the program.
- b. Identification of the family and the person representing the family.
- c. A clear description of the barrier to self-sufficiency to be considered.
- d. Demonstration of how removing the barrier is related to obtaining or retaining employment, meeting the criteria in rule 441—47.4(239B).
- e. Demonstration of why the department, PROMISE JOBS, or community resources cannot deal with the barrier to self-sufficiency.
- f. Anticipated cost of removing the barrier to self-sufficiency.

47.5(2) *Notification process.* PROMISE JOBS shall use a form prescribed by the department to notify the candidate of the PROMISE JOBS decision regarding the family self-sufficiency grant. Decisions shall be in accordance with policies of this chapter and the local plan.

- a. On approval, the form shall indicate the amount of the benefit that will be issued to the candidate or paid to a vendor, or the service that will be provided to the family.
- b. On denial, the form shall indicate the reason for denial.

47.5(3) *Appealable actions.* The PROMISE JOBS decisions on family self-sufficiency grants may be appealed pursuant to 441—Chapter 7. Copies of the local plan as described in rule 441—47.6(239B) shall be included with the appeal summary.

47.5(4) *Nonappealable actions.* PROMISE JOBS participants will not be entitled to an appeal hearing if the sole basis for denying, terminating or limiting assistance from family self-sufficiency

grants is that self-sufficiency grant funds have been reduced, exhausted, eliminated, or otherwise encumbered.

441—47.6(239B) Approved local plans for family self-sufficiency grants. Each IWD service delivery area shall create and provide to the department the written policies and procedures for administering family self-sufficiency grants. The plan will be reviewed for required elements and quality of service to ensure that it meets the purpose of the program and approved by the department and the appropriate responsible administrator. The written policies and procedures shall be available to the public at county offices, and PROMISE JOBS offices. At a minimum, these policies and procedures shall contain or address the following:

47.6(1) *A plan overview.* The plan overview shall contain a general description detailing:

- a. Any types of services or assistance that will be excluded from consideration for family self-sufficiency grants by the IWD service delivery area.
- b. How determinations will be made that the service or assistance requested meets the program's objective of helping the family obtain or retain employment.
- c. How determinations will be made that the proposed family self-sufficiency grant is not supplanting as required in subrule 47.4(5).
- d. Services established and any maximum (and minimum, if any) values of payments of the services established by the IWD service delivery area.
- e. Verification procedures or standards for documenting barriers, using written notification policies found in rule 441—93.10(239B).
- f. Verification procedures or standards for documenting employment attempts if not already tracked by PROMISE JOBS procedures, using policies found in rule 441—93.10(239B).
- g. How applications will be processed timely to address barriers to obtaining or retaining employment.
- h. Follow-up procedures on participant effort.
- i. Procedures for tracking of family self-sufficiency grant authorizations in order to stay within the amount allocated.
- j. How staff will be trained to administer the program.

47.6(2) *Intake and eligibility determination.* The policies and procedures shall describe:

- a. How families most likely to benefit from self-sufficiency grant assistance are identified.
- b. How families can apply for self-sufficiency grant assistance.
- c. How families will be informed of the availability of self-sufficiency grant assistance, its voluntary nature, and how the program works.

441—47.7(239B) Evaluation of family self-sufficiency grants. The department, in conjunction with IWD, will develop an evaluation plan. The evaluation plan will:

1. Describe tracking procedures.
2. Describe the plan for evaluation.
3. Describe how measurable results will be determined.
4. Identify any support needed to conduct an evaluation.

441—47.8(239B) Recovery of FSSG overpayments. An overpayment exists when an item(s) for which the funds were awarded was not purchased, a duplicate payment was issued or when, according to receipts, the item(s) purchased costs less than the funds received. For purposes of overpayment and recovery, an FSSG payment is considered a PROMISE JOBS expense payment and is subject to rule 441—93.12(239B), recovery of PROMISE JOBS expense payments.

These rules are intended to implement Iowa Code sections 234.6 and 239B.11.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 49
“Family Development and Self-Sufficiency Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 216A.107

State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 12, 2024
1 to 2 p.m.

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by 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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliance@hhs.iowa.gov

Purpose and Summary

These proposed rules define and structure the Family Development and Self-Sufficiency (FaDSS) program administered by the Department. The purpose of the program is to fund, evaluate, and provide recommendations on programs that provide services to assist families at risk of instability or dependency on the Family Investment Program (FIP) to move toward self-sufficiency.

These rules establish provisions for the grant proposal process and the awarding of grants, grant contract provisions, criteria and conditions for at-risk families, provisions for referral of families, grantee responsibilities, and the requirement for program evaluation.

Finally, the rules are being moved from the legacy Human Rights Administrative Code agency number [421] to a new chapter within the Health and Human Services agency number [441]. These rules were previously located in 421—Chapter 24.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Families that are at risk of instability or dependency on the FIP will benefit.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
In state fiscal year 2024, 15 grantee agencies supported 2,175 families.

- Qualitative description of impact:

FaDSS engages families in dynamic partnerships to address their basic needs, improve child well-being, and develop career opportunities that, in turn, improves lives, families, and communities.

This rulemaking implements 2024 Iowa Acts, Senate File 2385, as well as facilitates agency alignment.

3. Costs to the State:

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

Personnel and other administrative costs.

- Anticipated effect on state revenues:

There is 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 required due to the elimination of the FaDSS Council pursuant to 2024 Iowa Acts, Senate File 2385. This rulemaking also facilitates state agency alignment by placing the rules within the Health and Human Services Department agency number.

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:

None.

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

This rulemaking is required due to the elimination of the FaDSS Council pursuant to 2024 Iowa Acts, Senate File 2385. It is also necessary to move this chapter to Health and Human Services' agency number due to the state of Iowa's agency alignment initiative.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Adopt the following **new** 441—Chapter 49:

CHAPTER 49

FAMILY DEVELOPMENT AND SELF-SUFFICIENCY (FaDSS) PROGRAM

441—49.1(216A) Definitions. As used in these rules, unless the context otherwise requires:

“*Applicant*” means a public or private organization that applies for a family development and self-sufficiency grant through the request for proposal process.

“*Council*” means the council on health and human services.

“*Grant*” means an award approved by the council to fund a family development and self-sufficiency project.

“*Grantee*” means an applicant whose proposal is selected by the council and who enters into a grant agreement with the department.

“*Program*” or “*FaDSS program*” means the family development and self-sufficiency (FaDSS) program.

“*Proposal*” or “*grant proposal*” means an application for grant funds to fund specific projects.

441—49.2(216A) Identification of conditions and criteria for families at risk. The council has identified the following conditions and criteria that may place families at risk of instability or of long-term dependency on the family investment program:

49.2(1) *Educational level of head of household.*

- a. Head of household has less than a high school education.
- b. Head of household lacks basic literacy skills.

49.2(2) *Work experience of head of household.*

- a. Head of household has never been employed.
- b. Head of household has multiple episodes of employment lasting less than one year.
- c. Head of household is currently unemployed.

49.2(3) *Household composition.*

- a. Members are homeless or nearly homeless.
- b. Members outside the nuclear family are in residence.
- c. One or more children in the household were born while the parent received public assistance.
- d. One or more children in the household are identified as having special needs.
- e. Household includes a family member with substantiated substance use issues.
- f. Household includes a past or current perpetrator of child abuse or domestic violence.
- g. Household includes a member with a record of incarceration.

49.2(4) *Background of head of household.*

- a. Head of household was a teenager at birth of first child.
- b. Head of household has a disability or chronic illness (mental or physical).
- c. Head of household is a past or current victim of child abuse or domestic violence.
- d. Head of household grew up in a household with substance abuse.

49.2(5) *Public assistance history.*

- a. Head of household grew up in a household that received public assistance.
- b. Household has experienced multiple episodes of receipt of public assistance.
- c. Household has been on public assistance for three or more years.

49.2(6) *Other conditions.* The council has also identified the following conditions that may contribute to instability or long-term dependency:

- a. Lack of employment opportunity.
- b. Lack of available services.
- c. Lack of transportation.

441—49.3(216A) Referral of families. Families who meet one or more of the conditions and criteria identified in rule 441—49.2(216A) may be referred to the program by the department, the department of workforce development, family self-referral, or other sources. Grantees will determine eligibility for the program in accordance with the eligibility criteria determined by the department.

441—49.4(216A) Funding of grants.

49.4(1) *Availability of funds.* The council will develop requests for proposals for the awarding of grants, subject to availability of funds. Grants will not exceed 60 months; however, the department will approve grantee budgets on an annual basis, based upon and subject to available funds.

49.4(2) *Grant application process.* The department will distribute applications for grants through a request for proposal. Applications shall be submitted to the department in accordance with the instructions indicated in the request for proposal.

49.4(3) *Grant proposals.* Grant proposals for the program must include all elements outlined in the application as determined by the council.

49.4(4) *Selection of grant proposals.* All proposals timely received will be reviewed by the department, which will make recommendations to the council. The council will review the projects recommended by the department and make the final decision with respect to grant awards.

49.4(5) *Notification of applicants.* Applicants will be notified of grant award decisions within 60 days after the due date for receipt of proposals.

441—49.5(216A) Grants not renewed and grants terminated or reduced. If the council determines that a grantee's project funding will not be renewed or if the council terminates or reduces a grantee's funding, the balance of funds not renewed or terminated or reduced will be awarded by the council to other grantees for which funding is approved, based on criteria approved by the council. In the event no previously approved grantees have been selected, the council will fund new grantees selected by the council as a result of a competitive grant application process.

441—49.6(216A) Appeal.

49.6(1) Applicants dissatisfied with the council's actions regarding grant proposals for funds and grantees dissatisfied with termination of a contract may appeal the council's decision in accordance with 441—Chapter 7.

49.6(2) In the case of a grant award, no disbursements will be made to a grantee for a period of ten calendar days following issuance of the notice of decision to award. If an appeal is filed within the ten days, all disbursements will be held pending a final decision on the appeal. All applicants will be notified if an appeal is filed.

441—49.7(216A) Contract with grantee. Funds for grants approved by the council will be awarded pursuant to a contract entered into by the department and the grantee.

49.7(1) *Negotiation.* The department will conduct contract negotiations with the selected applicant, including negotiations regarding possible modifications to a grant proposal.

49.7(2) *Withdrawal of contract offer.* If the applicant and the department are unable to successfully negotiate a contract, the council may withdraw the award offer and award the grant to the applicant with the next highest-scoring proposal.

49.7(3) *Contract revisions.* The department and the grantee may negotiate revisions to the contract to allow for nonmaterial expansion or modification of services so long as such revisions do not increase the total amount of the grant. The department has the right to approve an amendment to the contract budget moving grant funds between budget line items if the funds represent more than 10 percent of the budget line item. All contract amendments will be granted at the discretion of the department in accordance with the terms set forth in the contract.

441—49.8(216A) Grantee responsibilities. The grantee will be responsible for providing services in accordance with the policies and procedures set forth in the FaDSS program manual, the grant contract, and any other guidance from the department.

441—49.9(216A) Evaluation. The grantee will be evaluated by the department in accordance with the continuous quality improvement plan developed by the department.

These rules are intended to implement Iowa Code section 216A.107 as amended by 2024 Iowa Acts, Senate File 2385.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 50
“Application for Assistance”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A.4

State or federal law(s) implemented by the rulemaking: Iowa Code sections 249.3, 249.4, and 249A.4 and 20 CFR §416, subpart T

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines the application procedures and related criteria for state supplementary assistance programs administered by the Department.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
A person applying for state supplementary assistance will benefit.
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 March 2024, there were approximately 900 members enrolled in the state supplementary assistance programs administered by the Department. These rules provide for consistent eligibility determinations and accurate payments for the enrolled members and any future applicants of state supplementary assistance programs.
 - Qualitative description of impact:
These rules play an important role in providing additional context, specificity, structure and a legal basis for decisions made by the Department.
3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
The Department incurs personnel costs to implement the program.
 - Anticipated effect on state revenues:
There are no additional costs beyond those already appropriated.
4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:
The absence of these rules could lead to confusion or lack of clear legal authority.
5. Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:
A less costly method has not been identified to achieve the purpose of this rulemaking.
6. Alternative methods considered by the agency:
- Description of any alternative methods that were seriously considered by the agency:
None.
 - Reasons why alternative methods were rejected in favor of the proposed rulemaking:
Much of the benefit can be achieved through employee manuals and forms prescribed by the Department. However, an additional framework is needed to provide clarity, consistency and a legal basis for decisions made by the Department.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 50 and adopt the following **new** chapter in lieu thereof:

STATE SUPPLEMENTARY ASSISTANCE TITLE V CHAPTER 50 APPLICATION FOR ASSISTANCE

441—50.1(249) Definitions.

“Aged” means a person 65 years of age or older.

“Applicant” means a person who is requesting state supplementary assistance on the person’s own behalf or a person for whom state supplementary assistance is requested.

“Blind” means the same as defined in 20 CFR §416.981.

“Client” means a person who has been determined eligible and is a current or former recipient of state supplementary assistance.

“Disabled” means the same as defined in 20 CFR §416.905 or 20 CFR §416.906.

EXCEPTION: For the supplement for Medicare and Medicaid eligibles, being engaged in substantial gainful activity will not preclude a determination of disability. For purposes of state-administered payments, the department will determine disability according to 441—Chapter 75.

“Payment for a dependent relative” means a payment to a recipient on behalf of a dependent relative as defined in Iowa Code section 249.3(3).

“Payment for a protective living arrangement” means a payment to a recipient living in a family life home.

“Payment for residential care” means a payment to a recipient living in a residential care facility who is determined to be in need of care and payment is made on a per diem basis.

441—50.2(249) Application procedures.

50.2(1) In order to be eligible for state supplementary assistance, an aged, blind, or disabled person with need for a living arrangement as defined in Iowa Code section 249.3 shall be receiving supplemental security income benefits or shall meet all eligibility requirements for the benefits other than income, but have less income than the standards for the living arrangements as set forth in 441—Chapter 52 and 441—Chapter 177.

a. Payments for mandatory supplementation, blind allowance, dependent relative allowance, and the family life home program shall be federally administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit will be excluded in determining eligibility for or the amount of the state payment.

b. Payments for in-home, health-related care and residential care shall be state administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit, except the \$20 exclusion of any income, will be excluded in determining eligibility for or the amount of the state payment.

c. Payments for supplements for Medicare and Medicaid eligibles shall be state-administered. Income excluded in determining eligibility for the person’s Medicaid coverage group will be excluded in determining eligibility for the state payment.

50.2(2) Any person applying for payment for a protective living arrangement or payment for a dependent relative shall make application for supplemental security income at the Social Security Administration district office. The county office of the department of health and human services will certify to the Social Security Administration as to the nature of the living arrangement or the status of the dependent.

50.2(3) Any person applying for payment for residential care, a dependent person allowance, payment for a protective living arrangement, or in-home health-related care shall make application with the department of health and human services.

The application shall be made on a form prescribed by the department. The application shall be signed by the applicant or the authorized representative. Someone acting responsibly for an incapacitated, incompetent, or deceased person may sign the application on the person’s behalf.

a. Each person wishing to do so shall have the opportunity to apply for assistance without delay.

b. An applicant may be assisted by an authorized representative, as defined in rule 441—76.1(249A). If the applicant is unable to act on the applicant’s own behalf, a responsible person may act on the applicant’s behalf pursuant to rule 441—76.9(249A).

c. The department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or refusal to authorize the department to secure the information from other sources shall serve as a basis for denial of assistance.

50.2(4) An application for Medicaid from a person who meets the requirements of rule 441—51.6(249) will be considered as an application for the supplement for Medicare and Medicaid eligibles.

441—50.3(249) Approval of application and effective date of eligibility.

50.3(1) Payment for a federally administered payment category when the applicant is not an SSI recipient will be effective the month following the month that an application is filed or, if later, the month following the month that all eligibility criteria are met, pursuant to 42 U.S.C. §1382(c)(7).

Payment for a federally administered payment category when the applicant is an SSI recipient will be effective as of the first day of the month in which an application is filed or the first day of the month in which all eligibility criteria are met, whichever is later, notwithstanding 42 U.S.C. §1382(c)(7).

50.3(2) Payment for residential care will be effective as of the date that eligibility first exists, notwithstanding 42 U.S.C. §1382(c)(7), but in no case will the effective date be earlier than 30 days prior to the date of application.

50.3(3) The application for residential care will be approved or denied within five working days after the Social Security Administration approves supplemental security income benefits. When supplemental security income benefits will not be received, the application will be approved or denied within five working days from the date of establishment of all eligibility factors.

50.3(4) Payment for the supplement for Medicare and Medicaid eligibles will be effective retroactive to October 1, 2003, or to the first month when all eligibility requirements are met, whichever is later.

441—50.4(249) Reviews.

50.4(1) Any eligibility factor will be reviewed whenever a change in circumstances occurs.

50.4(2) All eligibility factors will be reviewed at least annually.

50.4(3) For purposes of an annual review to be performed by the department, the client shall complete and return a form prescribed by the department.

441—50.5(249) Application under conditional benefits. When the applicant or client is seeking state supplementary assistance (SSA) under the conditional benefit policy of the supplemental security income (SSI) program in accordance with 20 CFR §416.1242 as amended to March 15, 2022, the applicant or client are required to do the following:

50.5(1) Complete and return Form 470-2909.

50.5(2) Complete and return Form 470-2908 as follows:

a. For personal property, every 30 days during the conditional benefits period.

b. For real property, 35 days after conditional benefits are granted and every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the applicant or client shall complete the form every 90 days.

50.5(3) Sign an agreement to repay the state supplementary assistance granted during the conditional period using a form prescribed by the department. The amount of repayment is limited to the lesser of:

a. The amount by which the revised value of resources (resources counted at the beginning of the conditional period plus the net value of resources sold) minus both the resource limit and the amount that SSI recovers for conditional benefits.

b. The amount of state supplementary assistance actually paid in the conditional period, minus the amount that SSI recovers for conditional benefits.

These rules are intended to implement Iowa Code sections 249.3, 249.4 and 249A.4.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 51
“Eligibility”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6

State or federal law(s) implemented by the rulemaking: Iowa Code sections 249.3 and 249.4

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines eligibility criteria for state supplementary assistance programs administered by the Department.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
A person applying for, or interested in, state supplementary assistance will benefit.
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 March 2024, there were approximately 900 members enrolled in the state supplementary assistance programs administered by the Department. These rules provide for consistent eligibility determinations and accurate payments for the enrolled members and any future applicants of state supplementary assistance programs.
 - Qualitative description of impact:
These rules play an important role in providing clarity, specificity, structure and a legal basis for decisions made by the Department.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

The Department incurs personnel costs to implement the program.

- Anticipated effect on state revenues:

There are no additional costs beyond those already appropriated.

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

The absence of these rules could lead to confusion or lack of clear legal authority.

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

A less costly method has not been identified to achieve the purpose of this rulemaking.

6. Alternative methods considered by the agency:

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

None.

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

Much of the benefit can be achieved through employee manuals and forms prescribed by the Department. However, an additional framework is needed to provide clarity, consistency and a legal basis for decisions made by the Department.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 51 and adopt the following **new** chapter in lieu thereof:

CHAPTER 51 ELIGIBILITY

441—51.1(249) Definitions.

“*Administrative overpayment*” means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

“*Agency error*” means assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.

5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the local office.

6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

“Client” means a person who has been determined eligible and is a current or former recipient of state supplementary assistance.

“Client error” means assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report changes as described in 441—Chapter 76.

441—51.2(249) Application for other benefits. An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

441—51.3(249) Supplementation. Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity will be considered as income, and the payment will be used to reduce the state supplementary assistance payment.

441—51.4(249) Eligibility for residential care.

51.4(1) Licensed facility. Payment for residential care can only be made when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections, appeals, and licensing pursuant to laws governing health care facilities.

51.4(2) Physician’s statement. Payment for residential care must be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification will be updated whenever a change in the recipient’s physical condition warrants reevaluation, but no less than every 12 months.

51.4(3) Income eligibility. The resident is income eligible when the income according to 441—paragraph 52.1(3) “a” is less than 31 times the maximum per diem rate. Partners in a marriage who both enter the same room of the residential care facility in the same month will be income eligible for the initial month when their combined income according to 441—paragraph 52.1(3) “a” is less than twice the amount of allowed income for one person (31 times the maximum per diem rate).

441—51.5(249) Dependent relatives.

51.5(1) Income. Income of a dependent relative must be less than the amount established by the department based on assistance standards as provided in rule 441—52.1(249). When the dependent’s income is from earnings, an exemption of \$65 will be allowed to cover work expense.

51.5(2) Resources. The resource limitation for a recipient and a dependent child or parent is \$2,000. The resource limitation for a recipient and a dependent spouse is \$3,000. The resource limitation for a recipient, spouse, and dependent child or parent is \$3,000.

51.5(3) Living in the home. A dependent relative is eligible until out of the recipient’s home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

51.5(4) Dependency. A dependent relative may be the recipient’s ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative will not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

441—51.6(249) Residence. A recipient of state supplementary assistance must be living in the state of Iowa.

441—51.7(249) Eligibility for supplement for Medicare and Medicaid eligibles. The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

51.7(1) Medicaid eligibility. The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spend down or pay a premium to be eligible for medical assistance benefits.

51.7(2) SSI eligibility. The recipient must meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

51.7(3) Not otherwise eligible. The recipient must not be eligible for benefits under another state supplementary assistance group.

51.7(4) Medicare eligibility. The recipient must be currently eligible for Medicare Part B.

51.7(5) Living arrangement. A recipient may live in one of the following:

- a. The person's own home.
- b. The home of another person.
- c. A group living arrangement.
- d. A medical facility.

51.7(6) Income. Income of a recipient must be within the income limit for the person's Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.

441—51.8(249) Income from providing room and board. In determining income from furnishing room and board or providing family-life home care, the amount established by the department based on assistance standards as provided in rule 441—52.1(249) will be deducted to cover the cost, and the remaining amount will be treated as earned income.

441—51.9(249) Furnishing of social security number.

51.9(1) As a condition of eligibility applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

51.9(2) Assistance will not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

441—51.10(249) Recovery.

51.10(1) Amount subject to recovery. The department will recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

a. The department will seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

b. The incorrect expenditures may result from client or agency error, or administrative overpayment.

51.10(2) Notification. All clients will be promptly notified when it is determined that assistance was incorrectly expended. Notification will include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

51.10(3) Source of recovery. Recovery will be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

51.10(4) *Repayment.* The repayment of incorrectly expended state supplementary assistance funds will be made to the department.

51.10(5) *Appeals.* The client has the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

These rules are intended to implement Iowa Code sections 249.3 and 249.4.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 52
“Payment”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249 and 20 CFR §416,
Subpart T

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines payment criteria and details for state supplementary assistance programs administered by the Department.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Persons eligible for state supplementary assistance will benefit.
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 March 2024, there were approximately 900 members enrolled in the state supplementary assistance programs administered by the Department. These rules provide for consistent eligibility determinations and accurate payments for the enrolled members and any future applicants of state supplementary assistance programs.
 - Qualitative description of impact:
These rules play an important role in providing clarity, specificity, structure and a legal basis for determining financial need and the amount of assistance granted.
3. Costs to the State:

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

The Department incurs personnel costs to implement the program.

- Anticipated effect on state revenues:

There are no additional costs beyond those already appropriated.

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

The absence of these rules could lead to confusion or lack of clear legal authority.

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

A less costly method has not been identified to achieve the purpose of this rulemaking.

6. Alternative methods considered by the agency:

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

None.

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

Much of the benefit can be achieved through employee manuals and forms prescribed by the Department. However, an additional framework is needed to provide clarity, consistency and a legal basis for determining financial need and the amount of assistance granted.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 52 and adopt the following **new** chapter in lieu thereof:

CHAPTER 52 PAYMENT

441—52.1(249) Assistance standards. Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted. Current assistance standards will be published on the department's website. Assistance standards will be adjusted annually to reflect cost-of-living adjustments (COLA) adopted by the Social Security Administration, in accordance with 20 CFR §416.2095 and 20 CFR §416.2096 as amended to March 15, 2022. Adjustments to the assistance standards based on COLA are effective January 1 of each year.

52.1(1) *Protective living arrangement.* Assistance standards will be established by the department as provided in this chapter for care and personal allowances for persons living in a family-life home certified under rules in 441—Chapter 111.

52.1(2) *Dependent relative.* Assistance standards for the following categories will be established by the department as provided in this chapter for state supplementary assistance for dependent relatives residing in a recipient's home.

- a. Aged or disabled client and a dependent relative.
- b. Aged or disabled client, eligible spouse, and a dependent relative.
- c. Blind client and a dependent relative.
- d. Blind client, aged or disabled spouse, and a dependent relative.
- e. Blind client, blind spouse, and a dependent relative.

52.1(3) *Residential care.* For periods of eligibility before July 1, 2017, the department will reimburse a recipient in either a privately operated or non-privately operated residential care facility on a flat per diem rate or on a cost-related reimbursement system with a maximum per diem rate established consistent with the assistance standards principles provided in this chapter.

For periods of eligibility beginning July 1, 2017, and thereafter, payment to a recipient in a licensed residential care facility will be based on the maximum per diem rate.

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule will be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care will be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

(1) When income is earned, impairment related work expenses, as defined by SSI plus \$65 plus one-half of any remaining earned income.

(2) An allowance established by the department consistent with this chapter will be given to meet personal expenses and Medicaid copayment expenses.

(3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse's countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard will be made.

(4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent's countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.

(5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, will be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, will also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family-life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry will not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

b. Payment is made for only the days the recipient is a resident of the facility. Payment must be made for the date of entry into the facility, but not the date of death or discharge.

c. Payment must be made in the form of a grant to the recipient on a post payment basis.

d. Payment must not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

e. Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year, unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence that exceeds the 30-day annual limit. This information must be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, on a form prescribed by the department, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions detailed in rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

f. Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

52.1(4) *Blind.* The standard for a blind recipient not receiving another type of state supplementary assistance is \$22 per month.

52.1(5) *In-home, health-related care.* Payment to a person receiving in-home, health-related care must be made in accordance with rules in 441—Chapter 77.

52.1(6) *Minimum income level cases.* The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions that were in effect in October 1972 shall be utilized.

52.1(7) *Supplement for Medicare and Medicaid eligibles.* Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be \$1 per month.

This rule is intended to implement Iowa Code chapter 249.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 54
“Facility Participation”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6

State or federal law(s) implemented by the rulemaking: Iowa Code section 249.12 and 20 CFR 416, Subpart T

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed chapter is to provide criteria for eligibility, payments, services, and billing for residential care facility supplemental payment.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Residents of care facilities that receive state supplementary assistance as outlined in Iowa Code chapter 249 will benefit.
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:
These rules will apply to the 392 nursing facilities, 107 residential care facilities (three- and five-bed), and the 74 intermediate care facilities for individuals with intellectual disabilities.
 - Qualitative description of impact:
Having the rules in place sets standards that residential care facilities must maintain, including the maintenance of personal needs accounts for residents.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

Personnel and other administrative costs.

- Anticipated effect on state revenues:

There is no impact on state revenues.

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

Not having standards for facilities could be detrimental to the health and well-being of residents of residential care facilities.

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

A rule, coupled with a contract, is the appropriate way to enforce the requirements of Iowa Code chapter 249.

6. Alternative methods considered by the agency:

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

None were considered.

- 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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 54 and adopt the following **new** chapter in lieu thereof:

CHAPTER 54 FACILITY PARTICIPATION

441—54.1(249) Application and contract agreement. Each facility desiring to participate in the state supplementary assistance program must enter into a contract with the department and agree to the provisions set forth in a contract in a form prescribed by the department. The effective date of the contract shall be the first of the month that the form is signed by the administrator of the facility and is received by the department. No payment shall be made for care provided before the effective date of the contract. The contract shall be in effect until the department ceases to participate in the program, until either party gives 60 days' notice of termination in writing to the other party, or until there is a change in ownership. The facility shall notify the department within 30 days of a change in ownership, a change in the number of beds or a change in administrator.

This rule is intended to implement Iowa Code section 249.12.

441—54.2(249) Maintenance of case records. A facility must maintain a case folder for each individual residing in the facility which contains the following:

1. Contract between the facility and the resident on a form prescribed by the department.
2. Physician's statement certifying that the resident does not require nursing services.
3. Proof of expenditures from resident's "personal needs" allowance.

This rule is intended to implement Iowa Code section 249.12.

441—54.3(249) Payments for residential care facilities. Payments for residential care facilities will be made at the maximum per diem rate in 441—subrule 52.1(3).

54.3(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in rule 441—79.3(249A).

54.3(2) Termination or change of ownership. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement.

This rule is intended to implement Iowa Code section 249.12.

441—54.4(249) Goods and services provided. All facilities participating in the program shall provide residents those goods and services required by the terms of the license issued by the department of inspections, appeals, and licensing in accordance with Iowa Code chapter 135C and rules promulgated thereto set forth in 481—Chapter 57 and requirements of the department set forth in these rules.

54.4(1) Payment accepted. The amount of client participation and the payment made through the state supplementary assistance program shall be accepted as payment in full for the required goods and services provided the resident. The facility may seek reimbursement from other sources for goods and services provided that are beyond the goods and services required to be provided by these rules.

54.4(2) Care, maintenance, general supervision, and personal services. Each facility as part of providing care, maintenance, general supervision, and personal services shall provide as necessary supervision or assistance with ambulation, grooming, hair washing, shaving, personal hygiene, bathing, getting in and out of bed, dressing, feeding, and with medication that can be self-administered.

54.4(3) Laundry. Each facility shall provide personal laundry service to the resident as part of the goods and services paid for through the program.

54.4(4) Room furnishings. The facility shall completely furnish the resident's room in accordance with 481—subrule 57.30(4) without additional charge to the resident or person acting on the resident's behalf. When the resident wishes to provide some item or items of room furnishing, the facility may grant the request.

This rule is intended to implement Iowa Code section 249.12.

441—54.5(249) Personal needs account. When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The personal needs funds shall be deposited in a single checking account, not commingled with trust funds from any other facility, nor commingled with facility operating funds except for facility funds, not to exceed \$500, deposited to cover bank charges and have in the account name the terms "Resident Trust Funds." The funds shall be deposited in a bank or other institution within the state of Iowa insured by the federal government. Expense for bank service charges for this account is a cost of doing business if the service cannot be obtained free of charge. The department

will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs allowance when such charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department, and shall meet the following criteria:

54.5(1) *Ledger.* Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

54.5(2) *Expenditures.* When something is purchased for the resident and is not a direct cash disbursement, each such expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

54.5(3) *Disbursement.* Personal funds shall be turned over only to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give the consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

54.5(4) *Audit.* The ledger and receipts for each recipient shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

54.5(5) *Death.* Upon a recipient's death the funds remaining in the personal needs account shall be treated in the following manner:

a. The facility shall provide a written statement of the personal needs account to be filed in the case record.

b. When an estate is opened, the funds shall be submitted to the estate administrator.

c. When no estate is opened, the funds shall be released to the person assuming responsibility for the recipient's funeral expenses.

d. When no estate is opened and there are no living heirs, the funds shall be submitted to the department to escheat to the state.

This rule is intended to implement Iowa Code section 249.12.

441—54.6(249) Case activity report. Whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility, the facility shall notify the department on a form prescribed by the department.

This rule is intended to implement Iowa Code section 249.12.

441—54.7(249) Billing procedures. In order to determine the amount of payment to the recipient, the facility shall submit a billing form to the department following the month in which service was provided.

This rule is intended to implement Iowa Code section 249.12.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 57
“Interim Assistance Reimbursement”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 1984 Iowa Acts, Chapter 1310
State or federal law(s) implemented by the rulemaking: 1984 Iowa Acts, Chapter 1310

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed chapter is to reimburse states and their political subdivisions that have furnished interim assistance in cash or in the form of vendor payments. This chapter provides additional clarity and structure for implementation.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
County agencies will benefit.
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:
These rules facilitate the reimbursement from the Social Security Administration to all 99 Iowa counties by way of 13 Mental Health and Disability Services (MHDS) regions.
 - Qualitative description of impact:
These rules will benefit county agencies seeking reimbursement for providing interim assistance to persons who are waiting on Supplemental Security Income (SSI) benefits. The clarity provided increases compliance with federal regulations and guidelines.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

There are no additional costs beyond those already appropriated.

- Anticipated effect on state revenues:

There is no impact.

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

Eliminating the rules entirely could lead to confusion or lack of available information for county agencies.

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

None were identified.

6. Alternative methods considered by the agency:

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

None.

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

Much of the benefit can be achieved through employee manuals and forms prescribed by the Department. However, an additional framework is needed to provide simplicity and consistency.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 57 and adopt the following **new** chapter in lieu thereof:

CHAPTER 57

INTERIM ASSISTANCE REIMBURSEMENT

441—57.1(249) Definitions.

“*Benefits*” means Supplemental Security Income (SSI) for the aged, blind, and disabled (a federal cash assistance program under Title XVI of the Social Security Act) and any federally administered state supplementary assistance payments that are determined by the Social Security Administration to be due an individual at the time the SSI payment is made.

“*County agency*” means a county or county subdivision under the jurisdiction of the county board of supervisors, including a county commission of veteran affairs, that furnishes relief in the form of cash or vendor payments to or in behalf of needy persons in accordance with established standards under the provisions of Iowa Code chapter 35B or 252.

“Initial payment” means the amount of benefits determined by the Social Security Administration to be payable to an eligible person (including any retroactive amounts) when the person is first determined to be eligible for SSI. The initial payment does not include any emergency advance payments, any presumptive disability or blindness payments, or any immediate payments authorized under Section 1631 of the Social Security Act.

“Initial posteligibility payment” means the amount of benefits determined by the Social Security Administration to be payable to an eligible person (including any retroactive amounts) when the person is first determined eligible for SSI following a period of suspension or termination. The initial posteligibility payment does not include any emergency advance payments, any presumptive disability or blindness payments, or any immediate payments authorized under Section 1631 of the Social Security Act.

“Interim assistance” means the same as defined in 20 CFR Part 416 as amended to August 1, 2024.

“Interim period” means either (1) the period beginning with the month following the month in which a person filed an application for benefits for which the person was found to be eligible and ending with and including the month the person’s benefits began, or (2) the period beginning the day the person’s benefits were reinstated after a period of suspension or termination, and ending with (and including) the month the person’s benefits were resumed. The interim period does not include any periods during which the person is underpaid by the Social Security Administration due to that agency’s failure to make a timely modification of the person’s SSI benefit or for any other reason.

441—57.2(249) Requirements for reimbursement. In order to receive reimbursement for interim assistance payments, a county agency must meet the following requirements.

57.2(1) Agreement. The county agency shall enter into a written agreement with the department of health and human services on a form prescribed by the department.

57.2(2) Authorization. The county agency shall secure written authorization from the person seeking interim assistance. By signing a form prescribed by the department, the person:

a. Indicates the intent to apply for SSI benefits.

b. Authorizes the Social Security Administration to:

(1) Withhold the amount of interim assistance from the person’s initial payment or initial posteligibility payment, and

(2) Make this amount payable to the county agency.

57.2(3) Records. The county agency shall:

a. Maintain a file for each person who has received interim assistance.

b. Maintain adequate records of all transactions made relating to interim assistance.

c. Comply with the provisions of the Federal Information Security Management Act (FISMA); 20 CFR Part 401 as amended to April 1, 2009; and the Privacy Act of 1974 relating to the safeguarding of information concerning individuals who have applied for interim assistance.

441—57.3(249) Certificate of authority.

57.3(1) The county agency shall submit the information requested on a form prescribed by the department to the Social Security Administration at the address given on the form:

a. Before the date the agency first participates in the program, and

b. Subsequently when changes in the list of authorized officials occur.

57.3(2) The county agency shall submit a copy of the form referenced in subrule 57.3(1) to the department at the address given on the form each time the form is submitted to the Social Security Administration.

These rules are intended to implement 1984 Iowa Acts, chapter 1310, section 9.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 60
“Refugee Cash Assistance”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6

State or federal law(s) implemented by the rulemaking: Iowa Code section 217.6

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50310
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

These proposed rules define and structure the Department’s Refugee Cash Assistance (RCA) program. Eligibility criteria, application procedures, reasons for adverse action, payment procedures, and recoupment procedures for overpayments are outlined in the proposed rules.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Refugee families applying for refugee cash assistance while seeking self-sufficiency will benefit.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
In federal fiscal year 2023, Iowa spent \$1,064,227 on RCA recipients.
 - Qualitative description of impact:
These rules play a vital role in the implementation of the program. Without this chapter, there would not be a consistent, fair and equitable program.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
The Department incurs personnel costs to implement the program.
 - Anticipated effect on state revenues:

No costs are anticipated beyond those already appropriated.

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

Ultimately, the goal of this program is to provide critical assistance to refugee families while they become self-sustainable. This program is a crucial piece of a larger effort to ensure families have access to safe housing and other necessities. These rules clearly define policies and procedures for the program.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

No alternative methods were considered.

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

Some of the benefit can be achieved through employee manuals. However, additional structure is needed to provide detailed procedure and a legal basis for decisions made by the Department.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 60 and adopt the following **new** chapter in lieu thereof:

CHAPTER 60 REFUGEE CASH ASSISTANCE

441—60.1(217) Alienage requirements.

60.1(1) Immigration status. A refugee is a person whose immigration status is one of the following statuses as issued by the United States Immigration and Naturalization Service:

- a. Granted asylum under Section 208 of the Immigration and Nationality Act.
- b. Admitted as a refugee under Section 207 of the Act.
- c. Paroled as a refugee or asylee under Section 212(d)(5) of the Act.
- d. Cuban and Haitian entrants in accordance with requirements in 45 CFR Part 401 as amended to March 22, 2000.

e. Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1988, as contained in Section 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Public Law 100-461).

f. Admitted for permanent residence, provided the individual previously held one of the statuses identified above.

60.1(2) *Nonrefugee child of refugee parents.* A nonrefugee child of refugee parents, when both parents in the home are refugees as defined in subrule 60.1(1), meets the alienage requirements. When only one parent is in the home and that parent is a refugee as defined in subrule 60.1(1), the child meets the alienage requirements.

60.1(3) *Immigration and Naturalization Service documents.* Each refugee shall provide Immigration and Naturalization Service documents in the form of either an I-94 card, an I-151 or I-551 card, an I-181 card, or other appropriate documentation to support the immigration status defined in subrule 60.1(1). If the name of the resettlement agency that resettled the refugee is not on the document, the refugee shall provide the name of the resettlement agency.

441—60.2(217) Application procedures. Application policies are defined in rules 441—40.3(239B), 441—40.4(239B), and 441—40.5(239B).

441—60.3(217) Effective date of grant. The date of eligibility for a grant is defined in rule 441—40.6(239B).

441—60.4(217) Accepting other assistance.

60.4(1) *Family investment program (FIP).* A refugee applicant or recipient shall accept a FIP grant if eligible under 441—Chapters 40 and 41.

60.4(2) *Supplemental security income (SSI).* Refugees who are 65 or older, blind, or disabled shall apply for and, if eligible, accept SSI.

441—60.5(217) Eligibility factors.

60.5(1) *Age.*

a. An unmarried refugee is considered an adult at age 18, except as defined in 441—subrule 41.1(1), and is eligible to receive refugee cash assistance if otherwise eligible.

b. Married refugees with or without children, as defined in 441—subrule 41.1(1), are eligible regardless of age if other eligibility factors are met.

60.5(2) *Residency.* Residency requirements are defined in 441—subrule 41.4(1).

60.5(3) *Social security numbers.* Refugees are required to furnish a social security number as defined in 441—subrule 41.3(11).

60.5(4) *Determination of need.* Need will be determined as defined in 441—41.9(239B), except as otherwise provided in this chapter.

60.5(5) *Income.* Income is defined in rules 441—40.1(239B) and 441—41.8(239B).

60.5(6) *Resources.* Resource requirements are defined in rule 441—41.7(239B).

441—60.6(217) Students in institutions of higher education. A refugee who is a full-time student in an institution of higher education (other than a correspondence school) is ineligible for assistance with two exceptions:

1. The refugee is in a program approved as part of an individual employability plan, as defined in subrule 60.9(3).

2. The refugee is in a program solely in English as a second language.

60.6(1) *Institution of higher education.* An institution of higher education is defined as an educational institution that provides an education program as specified below:

a. A public or private nonprofit institution of higher education is an educational institution that provides an educational program for which it awards an associate, baccalaureate, graduate, or professional degree; or at least a two-year program that is acceptable for full credit toward a baccalaureate degree; or at least a one-year training program that leads to a certificate or degree and prepares students for gainful employment in a recognized occupation.

b. A proprietary institution of higher education is an educational institution that provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

c. A postsecondary vocational institution is a public or private nonprofit educational institution that provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

60.6(2) *Full-time student.* A full-time student is a student who is carrying a full-time academic workload that equals or exceeds the following:

a. Twelve semester or 12 quarter hours per academic term in those institutions using standard semester, trimester, or quarter-hour systems.

b. Twenty-four semester hours or 36 quarter hours per academic year for institutions using credit hours to measure progress, but not using semester, trimester, or quarter systems, or the prorated equivalent for programs of less than one academic year.

c. Twenty-four clock hours per week for institutions using clock hours.

d. A series of courses or seminars that equals 12 semester hours or 12 quarter hours in a maximum of 18 weeks.

e. The work portion of a cooperative education program in that the amount of work performed is equivalent to the academic workload of a full-time student.

441—60.7(217) Time limit for eligibility.

60.7(1) *Assistance.* A refugee may receive assistance, if otherwise eligible:

a. For refugees who entered the country prior to October 1, 2021, during the first eight months the refugee is in the United States, beginning the month the refugee enters the country.

b. For refugees who entered the country on or after October 1, 2021, during the first 12 months the refugee is in the United States, beginning the month the refugee enters the country.

Exception: For asylees, the date of entry is the date asylum is granted. The 8-month or 12-month period of eligibility begins the month asylum is granted. A nonrefugee child in the home with a refugee parent (or refugee parents, if both are in the home) is eligible for assistance until the parent(s) has been in the United States for 8 or 12 months, or until the child reaches 8 or 12 months of age, whichever occurs first. For Afghan special immigrant (SI) parolees and Afghan SI conditional permanent residents (CPRs), the date is the date of “entry into the community,” which is the date the individual departed a safe haven. For Afghan humanitarian parolees, the date is the latter of October 1, 2021, or the date of entry into the community, which is the date the individual departed a safe haven. “Safe haven” is the term the U.S. government and other relevant stakeholders have used for U.S. military bases in the continental United States that housed Afghans evacuated under Operation Allies Refuge/Operation Allies Welcome (OAR/OAW) as Afghans awaited resettlement to their ultimate state of residence.

60.7(2) *Resources.* The resources of refugees excluded because of the 8-month or 12-month limit will be considered in the same manner as though these refugees were included in the eligible group.

60.7(3) *Income.*

a. When the eligible refugee group has income, the income will be diverted to meet the needs of the refugees ineligible because of the time limit who would otherwise have been included in the refugee assistance group as defined in subrule 60.5(4).

b. The income of the refugees ineligible because of the time limit who would otherwise have been included in the assistance group as defined in subrule 60.5(4), will be used first to meet the needs of the ineligible group and then applied to the eligible group’s needs.

c. The amount of need for the ineligible group is the difference between the needs of the group including the ineligible refugees and the needs of the group excluding the ineligible refugees. Any excess income will be applied to the needs of the eligible group.

d. Any cash grant received by the applicant under the Department of State or the Department of Justice reception and placement programs will be disregarded as income and as a resource.

441—60.8(217) Criteria for exemption from registration for employment services, registration, and refusal to register. Each refugee applying for or receiving cash assistance shall register for employment unless the department determines the refugee is exempt because of reasons listed in subrule 60.8(1). Inability to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs and acceptance of appropriate offers of employment.

60.8(1) Exemptions. The following refugees are exempt from registration:

a. A refugee who is under the age of 16; or who is aged 16 but under the age of 18 and attending elementary, secondary, or vocational or technical school full-time; or a refugee who is enrolled full-time in training approved by the local office as part of an approved employability plan; or a refugee 18 years of age who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching the age of 19.

(1) A refugee will be considered as attending school full time when enrolled or accepted full time (as certified by the school or institute attended) in a school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) The refugee also will be considered in regular attendance in months when the refugee is not attending because of an official school or training program, vacation, illness, convalescence, or family emergency. A refugee meets the definition of regular school attendance until the refugee has been officially dropped from the school rolls.

(3) When the refugee's education is temporarily interrupted pending adjustment of the education or training program, assistance will be continued for a reasonable period of time to complete the adjustment.

b. A refugee aged 65 or older.

c. A refugee who is caring for another member of the household who has a physical or mental impairment that requires, as determined by a physician or licensed or certified psychologist and verified by the department, care in the home on a substantially continuous basis, and no other appropriate member of the household is available.

d. A woman who is pregnant if it has been medically verified that the child is expected to be born in the month in which registration would otherwise be required or within the next six months.

e. A parent or other caretaker relative of a child under the age of three who personally provides full-time care for the child with only very brief and infrequent absences from the child. Only one parent or other caretaker relative in a case may be exempt under this paragraph. "Brief and infrequent absence" means short-term absences that do not reoccur on a regular basis. Any involvement by the parent employed less than 129 hours per month or attending school less than full-time, as defined by the school, will be considered brief and infrequent. Recreational activities and vacations by the parent or child that result in the parent being absent from the child will be considered brief and infrequent.

f. A refugee who is working at least 30 hours a week in unsubsidized employment expected to last a minimum of 30 days. This exemption continues to apply if there is a temporary break in full-time employment expected to last no longer than ten workdays.

g. A refugee who is ill, when determined by the department on the basis of medical evidence or another sound basis that the illness or injury is serious enough to temporarily prevent entry into employment or training.

h. A refugee who is incapacitated, when determined by a physician or licensed or certified psychologist and verified by the department, that a physical or mental impairment, by itself or in conjunction with age, prevents the refugee from engaging in employment or training.

60.8(2) *Registration.* A refugee not exempt under subrule 60.8(1) will be considered an employable refugee. An employable refugee shall register with the department of workforce development and, within 30 days of receipt of aid, participate in the employment services provided by the bureau of refugee services. The department does permit, but does not mandate, the voluntary registration for employment services of any applicant or recipient of refugee cash assistance who is exempt under the provisions of this rule. If a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the bureau of refugee services may de-register the refugee for up to 90 days from the date of determination that failure or refusal has occurred, but the refugee's cash assistance will not be affected.

60.8(3) *Refusal to register.*

a. An employable applicant refugee who refuses or fails to cooperate in accepting a referral to the department of workforce development or the bureau of refugee services, refuses or fails to appear at the department of workforce development office for registration, or refuses or fails to mail or deliver the registration form to the bureau of refugee services, will be denied assistance.

b. Assistance for an employable recipient refugee will be terminated when the refugee refuses or fails to register with the department of workforce development or the bureau of refugee services.

441—60.9(217) Work and training requirements.

60.9(1) *Standards applicable to both work and training assignments.* The following standards must be met before an employable refugee can be required to accept a work or training assignment. A job offered, if determined appropriate under subrules 60.9(1) and 60.9(2), is required to be accepted by the refugee without regard to whether the job would interrupt a program of services planned or in progress unless the refugee is currently participating in a program in progress of on-the-job training or vocational training approved as part of an individual's employability plan or the refugee is enrolled full-time in a professional recertification program approved as part of an individual's employability plan.

a. The job or training referral must be related to the physical and mental capability of the person to perform the task on a regular basis. Any claim of adverse effect on physical or mental health will be based on adequate medical testimony from a physician or licensed or certified psychologist indicating that participation would impair the person's physical or mental health.

b. The total daily commuting time to and from home to the work or training site to which the person is referred shall not normally exceed two hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance and time is generally accepted in the community, in which case the round trip commuting time shall not exceed the generally accepted community standards.

c. The work or training site to which the person is referred must not be in violation of applicable federal, state, and local health and safety standards.

d. Referrals shall not be made that are discriminatory in terms of age, sex, race, creed, color, or national origin.

e. When child care is required, the child care must meet state licensing or registration requirements.

f. Available manpower statistics for a local area must indicate adequate employment potential for persons obtaining the given training. The employment must also meet the other appropriate work requirements.

g. The work or training assignment must be within the scope of the refugee's employability plan.

h. The quality of training must meet local employers' requirements so that the refugee will be in a competitive position within the local labor market. The training must also be likely to lead to employment that will meet the appropriate work criteria.

i. If a refugee is a professional in need of professional refresher training and other recertification services in order to qualify to practice the refugee's profession in the United States, the training may consist of full-time attendance in a college or professional training program, provided that the training is approved by the department as a part of the refugee's employability plan; it does not exceed one year's duration (including any time enrolled in the program in the United States prior to the refugee's application for assistance); it is specifically intended to assist the professional in becoming relicensed in the refugee's profession; and, if completed, it can realistically be expected to result in relicensing.

60.9(2) *Appropriate work requirements.* The local office, in making a determination of appropriate work, shall utilize the following criteria:

a. Appropriate work may be temporary, permanent, full-time, part-time, or seasonal work if it meets the other work standards defined in subrule 60.9(1).

b. The wage shall meet or exceed the federal or state minimum wage law, whichever is applicable, or if these laws are not applicable, the wage shall not be less favorable than the wage normally paid for similar work in that labor market but in no event shall it be less than three-fourths of the minimum wage rate.

c. The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

d. No person shall be required to accept employment if:

(1) The position offered is vacant due to a strike, lockout, or other bona fide labor dispute.

(2) The person would be required to work for an employer contrary to the conditions of the person's existing membership in the union governing that occupation. However, employment not governed by the rules of a union in which the person has membership may be deemed appropriate.

60.9(3) *Development of an individual employability plan.* An individual employability plan will be developed as a part of a family self-sufficiency plan where applicable for each recipient of refugee cash assistance in a filing unit who is not exempt under subrule 60.8(1). The individual employability plan will:

a. Be designed to lead to the earliest possible employment and not be structured in such a way as to discourage or delay employment or job seeking.

b. Contain a definite employment goal, attainable in the shortest time period consistent with the employability of the refugee in relation to job openings in the area.

60.9(4) *Job search requirements.* The department will mandate job search for employable refugees where appropriate.

a. An employable recipient of refugee cash assistance shall carry out a job search program beginning at any time mandated by the bureau of refugee services. The bureau of refugee services will require the job search program to begin no later than six months after the refugee entered the United States or at the time the refugee is determined eligible for refugee cash assistance, if the refugee has completed at least six months in the United States at the time of the determination.

b. The job search program shall continue for at least eight consecutive weeks and shall meet requirements that the bureau of refugee services determines appropriate, including the amount of time to be devoted to employer contacts per week or the number of employer contacts mandated per week.

c. The department will determine and carry out the procedures it considers necessary to ensure that mandates for participation in job search are met.

60.9(5) *Failure or refusal to accept employability services or employment.*

a. Unless the refugee is exempt as described at rule 441—60.8(217), the department will terminate assistance when an employable recipient of refugee cash assistance has failed or refused to comply with any of the following requirements without good cause. The refugee shall:

(1) Register for employment with the department of workforce development and, within 30 days of receipt of cash assistance, participate in employment services provided by the bureau.

(2) Apply for or accept an offer of employment meeting the standards above.

(3) Carry out job search.

- (4) Go to a job interview arranged by the department or its designee.
 - (5) Participate in an employability service program that is determined to be available and appropriate for that refugee.
 - (6) Not voluntarily quit a job.
 - (7) Participate in a social service or targeted assistance program that the department determines to be available and appropriate for that refugee.
- b.* In cases of proposed action to terminate, discontinue, suspend, or reduce assistance, the department will give timely and adequate notice, following the same procedures as those used in the family investment program. The written notice will include:
- (1) An explanation of the reason for the action and the consequences of failure or refusal.
 - (2) Notice of the refugee's right to file an appeal with the department. The department will determine whether a hearing will be granted.
- c.* For the first refusal or failure the refugee will be sanctioned for three payment months. Subsequent refusals or failures will result in a six-payment month sanction for each refusal or failure.
- d.* If the sanctioned individual is the only member of the filing unit, the assistance will be terminated. If the filing unit includes other members, the department will not take into account the sanctioned individual's needs in determining the filing unit's need for assistance.
- e.* A conciliation period prior to the imposition of sanctions must be provided for in accordance with the following time limitations. The conciliation effort will begin as soon as possible, but no later than 10 days following the date of failure or refusal to participate, and may continue for a period not to exceed 30 days. Either the department or the recipient may terminate this period sooner when either believes that the dispute cannot be resolved by conciliation.

441—60.10(217) Uncategorized factors of eligibility.

60.10(1) *Duplication of assistance.* A refugee whose needs are included in a refugee cash assistance grant will not concurrently receive a grant under any other public assistance program administered by the department. Neither will a recipient concurrently receive a grant from a public assistance program in another state.

60.10(2) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive refugee cash assistance when the other party, obligated to provide the support, is able to fulfill that part of the contract.

60.10(3) *Participation in a strike.*

a. The spouse and children will be ineligible for assistance for any month in which the other spouse or parent is participating in a strike on the last day of the month.

b. Any person will be ineligible for assistance for any month in which the person is participating in a strike on the last day of that month.

c. Definitions of a strike and participating in a strike are defined in 441—paragraph 41.6(4) “c.”

60.10(4) *Restrictions.* Restrictions found in 441—subrule 41.6(7) apply to benefits issued under this chapter.

441—60.11(217) Temporary absence from home. Temporary absence from home is defined in 441—subrule 41.4(3).

441—60.12(217) Application. The application will be processed as defined in rule 441—40.2(239B).

441—60.13(217) Continuing eligibility. Continuing eligibility will be determined as defined in rule 441—40.7(239B), except that refugee cash assistance will be substituted for the family investment program whenever it appears.

441—60.14(217) Alternate payees. Alternate payees are defined in 441—Chapter 40, except that refugee cash assistance will be substituted for the family investment program whenever it appears.

441—60.15(217) Payment. Payment will be issued as defined in 441—Chapter 45, except that refugee cash assistance will be substituted for the family investment program whenever it appears.

441—60.16(217) Overpayment recovery. Recovery of overpayments will be determined as defined in 441—Chapter 46, except that refugee cash assistance will be substituted for the family investment program whenever it appears.

These rules are intended to implement Iowa Code section 217.6.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 61
“Refugee Services Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6

State or federal law(s) implemented by the rulemaking: Iowa Code sections 217.6 and 217.41; 8 U.S.C. §1522.42; 45 CFR §400.2; Immigration and Nationality Act, Title I, Section 101, and Title II, Chapter 1, Section 208; Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1988, as contained in Section 101(e) of Public Law 100-202 and amended by the ninth proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Public Law 100-461); Section 107(b) of the Trafficking Victims Protection Act of 2000, as contained in Public Law 106-386, Division A, 114 Stat. 1464 (2000)

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter is intended to define and structure the Department’s refugee services program, including eligibility criteria, application procedures, reasons for adverse actions, and appeal procedures for clients and sponsors.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who are eligible for refugee services will benefit.
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:

Refugee, immigrant and migrant services (RIMS) served 1,577 individuals in federal fiscal year 2023.

- Qualitative description of impact:

These rules will benefit the refugee population by helping them understand program eligibility criteria, application procedures, available services and reasons for adverse action.

3. Costs to the State:

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

No additional costs are anticipated beyond those already appropriated.

- Anticipated effect on state revenues:

This proposed rulemaking will have no effect on state revenues.

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

Eliminating the rules entirely could lead to confusion or lack of available information critical to this population.

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

No less costly or less intrusive methods were identified.

6. Alternative methods considered by the agency:

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

No alternative methods were seriously considered.

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

These rules outline and organize refugee resettlement activities in a manner that promotes the welfare and self-sufficiency of refugees who live in Iowa. Alternatives, such as a sole reliance on a state plan, would be subject to constant revision. This would cause inconsistencies and lack of clear authority and direction for the program.

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?

None identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 61 and adopt the following new chapter in lieu thereof:

CHAPTER 61 REFUGEE SERVICES PROGRAM

441—61.1(217) Definitions.

“Cash assistance” means the same as defined in 45 CFR §400 (June 7, 2022).

“Client” means refugees or others determined eligible for services funded under the refugee program.

“Family self-sufficiency plan” means a plan that addresses the employment-related service needs of the employable members in a family for the purpose of enabling the family to become self-supporting through the employment of one or more family members.

“Individual employability plan” means a written plan outlining an individual’s vocational goal and the services to be provided to reach the goal.

“Iowa state refugee program plan” means the report that describes the state of Iowa’s refugee program plan to meet the standards, goals, and priorities required under the Immigration and Nationality Act and developed by the department on the basis of a consultative process for the successful resettlement of refugees.

“Office of refugee resettlement” means the same as established in 8 U.S.C.A. §1521 (April 30, 1994).

“Refugee” means the same as defined in 8 U.S.C. §1101(a) INA 101 (a)(42) (January 5, 2023).

“Refugee unit” means either an individual refugee or two or more refugees representing an identifiable group, as determined by the department.

“Resettlement agency” means any business, organization or group of related persons having a current contract with the United States Department of State’s Bureau of Population, Refugees, and Migration for the resettlement of refugees within the United States of America.

“Unaccompanied refugee minor” means the same as defined in 6 U.S.C.A. §279 (December 23, 2008).

441—61.2(217) Authority. The department has been given authority to administer the refugee program by Executive Order Number 21, signed by the governor December 24, 1985. United States Department of State and United States Department of Health and Human Services rules govern various program operations.

441—61.3(217) Eligibility.

61.3(1) *Eligible immigration status.* Refugees eligible for services are those who have a status listed under 45 CFR §400.43 (June 7, 2022) or one of the following statuses:

a. Iraqi and Afghan Special Immigrants pursuant to Section 1244(g) of Div. A of PL 110-181 as amended (8 U.S.C. §1157 note) and Section 602(b)(8) of Div. F of PL 111-8 as amended (8 U.S.C. §1101 note).

b. Victims of a severe form of trafficking in persons per the Victims of Trafficking and Violence Protection Act of 2000, PL 106-386, as amended, and 22 U.S.C. §7105(b) (1) (A) and (C).

61.3(2) *Unaccompanied minors.* In addition to the unaccompanied minors in the categories listed under subrule 61.3(1), the following are eligible for the Office of Refugee Resettlement (ORR) Unaccompanied Refugee Minors Program:

a. Unaccompanied minor with special immigrant juvenile status under 8 U.S.C. §1101(a)(27)(J) who was in the custody of the secretary of health and human services at the time the dependency order was granted for such child or was receiving services pursuant to Section 501(a) of the Refugee Education Assistance act of 1980 (8 U.S.C. §1522 note) at the time such dependency order was granted.

b. Unaccompanied minor who has been granted U status pursuant to Section 101(a)(15)(U) of the Immigration and Nationality Act (8 U.S.C. §1101(a)(15)(U)).

441—61.4(217) Planning and coordinating the placement of refugees. Planning and coordination the placement of refugees will be established in the bureau of refugee services state plan as required

by the United States Department of State and United States Department of Health and Human Services.

441—61.5(217) Services of the department available for refugees. All services provided to the refugee and family have self-sufficiency as the goal. Direct and contracted services may include:

61.5(1) *Job development.* These services involve working with employers in job development, placement, training, retention, and upgrading.

61.5(2) *Social adjustment.* These services include assessment and short-term counseling to persons or families in a perceived crisis, referral to appropriate resources, the making of arrangements for necessary services, home management services, transportation, translation and interpretation services, and case management services.

61.5(3) *Health-related services.* These services include information, referral to appropriate resources, assistance in scheduling appointments and obtaining services, and counseling to individuals or families to help them understand and identify their physical and mental health needs and maintain or improve their physical and mental health.

61.5(4) *Resettlement services.* These services involve securing and training sponsors, arranging for refugees to resettle in Iowa and providing case management, employment services, and social adjustment services.

As required under the resettlement contract with the United States Department of State, the department provides case management, employment services, and social adjustment services to the refugees it resettles during their first 90 days in Iowa.

61.5(5) *Any additional service.* These services, upon submission to and approval of the director of the office of refugee resettlement, include any additional service aimed at strengthening and supporting the ability of a refugee individual, family, or refugee community to achieve and maintain economic self-sufficiency, family stability, or community integration which has been demonstrated as effective and is not available from any other funding source.

61.5(6) *Translation and interpretation services.* These services provide interpreter service from English into the refugee languages or vice versa and assistance in translating written materials.

61.5(7) *Immigration services.* These services provide information and assistance to refugees in securing permanent resident alien status and family reunification.

61.5(8) *Adjustment of status.* These services provide guidance in obtaining permanent alien status and citizenship.

61.5(9) *Employability services.* A family self-sufficiency plan will be developed for anyone who receives employment-related services from the department. These services are specifically designed to assist refugees to obtain employment and to improve the employability of work skills of the individual and include job referral to, and job placement with, private employers. Specific employability services include:

a. Employment services which include such activities as the development of a family self-sufficiency plan, individual employability plan, world-of-work and job orientation, job clubs, job workshops, job development, referral to job opportunities, job search, and job placement and follow-up.

b. Employability assessment services which include such activities as aptitude and skills testing.

c. English language instruction which includes referrals to programs which offer a curriculum which places an emphasis on English as it relates to obtaining and retaining a job and to programs which are provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

d. On-the-job training which includes referrals to training that is provided at the employment site and is expected to result in full-time, permanent, unsubsidized employment with the employer who is providing the training.

e. Vocational training which includes referrals to driver education and training when provided as part of an individual employability plan.

f. Skills recertification which includes referrals to training that meets the criteria for appropriate training. If an individual is a professional in need of professional refresher training and other recertification services in order to qualify to practice the individual's profession in the United States, the training may consist of full-time attendance in a college or professional training program, provided that such training:

- (1) Is approved as part of the individual's employability plan by the state agency, or its designee;
- (2) Does not exceed one year's duration (including any time enrolled in such program in the United States prior to the refugee's application for assistance);
- (3) Is specifically intended to assist the professional in becoming relicensed in the professional's profession; and
- (4) If completed, can realistically be expected to result in such relicensing. This training may only be made available to individuals who are employed.

g. Child care which includes referrals to child care necessary for participation in an employability service or for the acceptance or retention of employment.

h. Transportation when necessary for participation in an employability service or for the acceptance or retention of employment.

i. Translation and interpretation services when necessary in connection with employment or participation in an employability service.

j. Case management services for refugees who are considered employable and for recipients of public assistance who are considered employable, provided that the services are directed toward a refugee's attainment of employment as soon as possible after arrival in the United States.

k. Assistance in obtaining employment authorization documentations.

l. Referral to Iowa workforce development for provision of any or all of the above services.

61.5(10) Outreach services. These services include activities designed to familiarize refugees with available services, to explain the purpose of these services, and to facilitate access to these services.

61.5(11) Referral. These services enable referral of refugee clients to mainstream service systems.

441—61.6(217) Provision of services.

61.6(1) Priority of services. Services are provided to refugees in the following order of priority, except in certain individual extreme circumstances:

- a.* Refugees who are receiving cash assistance.
- b.* Unemployed refugees who are not receiving cash assistance.
- c.* Employed refugees in need of services to retain employment or to attain economic independence.
- d.* All newly arriving refugees in the United States who apply for services during the five-year period from their date of arrival.

61.6(2) Limitations on eligibility. Services as described in rule 441—61.5(217) may be provided in the first 60 months of resettlement unless the Office of Refugee Resettlement grants an exception to the 60-month limit. Referral, interpretation, citizenship, and naturalization services may be provided to the extent feasible past 60 months of resettlement for refugees, except that refugees who are receiving employability services, as defined in subrule 61.5(11), as part of an employability plan, as of September 30, 1995, may continue to receive those services through September 30, 1996, or until the services are completed, whichever occurs first, regardless of their length of residence in the United States, pursuant to 45 CFR 400 (June 7, 2022). In any case, services will first be provided for those refugees who are in the first two years of resettlement and who are in need of assistance in securing self-sufficiency.

61.6(3) Service requirements.

a. Services provided will be refugee-specific services which are designed specifically to meet refugee needs, except that vocational or job skills training, on-the-job training, or English language training need not be refugee specific.

b. Services will be provided, to the maximum extent feasible, in a manner that is culturally and linguistically compatible with a refugee's language and cultural background.

c. Services will be provided, to the maximum extent feasible, in a manner that includes the use of bilingual or bicultural women on service agency staffs to ensure adequate service access by refugee women.

d. The department will use its social service grants primarily for employability services designed to enable refugees to obtain jobs within one year of becoming enrolled in services in order to achieve economic self-sufficiency as soon as possible.

e. Social services may continue to be provided after a refugee has entered a job to help the refugee retain employment or move to a better job.

f. Social service grant funds may not be used for long-term training programs such as vocational training that last for more than a year or educational programs that are not intended to lead to employment within a year.

g. In planning and providing services, the department will take into account those services which a resettlement agency is required to provide for a refugee whom it sponsors in order to ensure the provision of coordinated services to refugees that are not duplicative.

h. To avoid interference with refugee employment, English language instruction and vocational training must be provided to the fullest extent feasible outside normal working hours.

i. English language instruction must be provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

441—61.7(217) Application for services. Any person will have an opportunity to apply for services by contacting the department or any of its affiliated offices either in person, by telephone, by fax, in writing, or by contacting any department staff members. The department will determine the eligibility of each person for services. Applicants for refugee cash assistance will automatically be considered as applicants for services. The department will ensure that refugee women have the same opportunities as refugee men to participate in all services, including job placement services.

441—61.8(217) Adverse service actions.

61.8(1) Denial. Services will be denied when the department determines any of the following apply:

- a. The client is not in need of the service.
- b. The client is not legally eligible.
- c. The service is not covered in the state refugee program plan.
- d. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.
- e. The service for which the client is eligible is currently not available.
- f. Funding is not available to provide the service.
- g. The client refuses to allow documentation of eligibility.
- h. The services requested are those for which other resettlement agencies are contractually responsible.
- i. The person requesting service has been in the United States more than 60 months and the services requested do not include referral, interpretation, citizenship, or naturalization services.

61.8(2) Termination. A service may be terminated when the department determines any of the following apply:

- a. The need to attain the goals to which the service was directed has been achieved.
- b. After repeated assessment, it is evident that the family or individual is unable to achieve or maintain goals set forth in the family self-sufficiency or individual employability plan.

- c. After repeated efforts, it is evident that the client is unwilling to accept further service.
- d. The service is no longer available in the Iowa state refugee program plan.
- e. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.
- f. Funding is not available to provide the service.
- g. The person receiving service has been in the United States more than 60 months and the services the person is receiving do not include referral or interpretation services.

61.8(3) *Reduction.* A service may be reduced when the department determines any of the following apply:

- a. Continued provision of service at its current level is not necessary. The department will determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal.
- b. Another community resource is available to provide the same or similar service to the client, at no financial cost to the client, that will meet the client's need.
- c. Funding is not available to continue the service at the current level. The client will be reassessed to determine the level of service to be provided.

61.8(4) *Notice of adverse action.* In case of an action to terminate, reduce, or deny services, the department will give timely or adequate notice to the person or persons affected pursuant to 441—Chapter 16.

441—61.9(217) Client appeals. Decisions made by the department or its designee adversely affecting its clients may be appealed according to 441—Chapter 7.

441—61.10(217) Refugee resettlement moneys. Money that is made available to the refugee sponsor for financial assistance in resettling the refugee unit must be spent in accordance with financial requirements and approved expenditures of the department, United States Department of State, and the state of Iowa comptroller and must go toward the benefit of the refugee unit.

441—61.11(217) Unaccompanied refugee minors program. The department administers the unaccompanied refugee minors program under 441—Chapters 156, 112 through 116, and 202 and by federal guidelines provided by the United States Department of Health and Human Services. In consultation with other resettlement agencies, the director of the ORR determines the number of unaccompanied minors to be resettled in Iowa pursuant to 45 CFR 400 (June 7, 2022). Resettlement agencies will not bring unaccompanied minors into Iowa without the authorization of the director.

441—61.12(217) Targeted assistance grants. “Targeted assistance grants” means United States Department of Health and Human Services formula allocation funding granted to the department for assistance to counties where, because of factors such as unusually large refugee populations (including secondary migration), high refugee concentrations, and high use of public assistance by refugees, there exists and can be demonstrated a specific need for supplementation of available resources for services to refugees.

61.12(1) *Administration of targeted assistance grants.* The department will make 95 percent of the total award available to the designated county except when the designated county has agreed to let the department administer the targeted assistance grant in its stead.

61.12(2) *Eligibility for services under targeted assistance grants.* Services funded by targeted assistance grants are limited to refugees who reside in the designated county.

61.12(3) *Services and limitations for services funded by targeted assistance grants.* Rules of 441—Chapter 61 are applicable to services funded by targeted assistance grants, except for subrules 61.5(5) and 61.6(1).

61.12(4) *Priority of services.* Services funded by targeted assistance grants will be provided in the following order of priority, except in certain individual extreme circumstances:

- (1) Cash assistance recipients, particularly long-term recipients.

- (2) Unemployed refugees who are not receiving cash assistance.
- (3) Employed refugees in need of services to retain employment or to attain economic independence.

These rules are intended to implement Iowa Code sections 217.6 and 217.41 and chapter 622A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 62
“Rent Reimbursement”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 425.16 through 425.40
State or federal law(s) implemented by the rulemaking: Iowa Code sections 425.16 through 425.40

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

Public Comment

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

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: vdaniel@dhs.state.ia.us

Purpose and Summary

This rulemaking provides guidance on eligibility for and parameters of Iowa’s Rent Reimbursement Program.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs to the proposed rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who are eligible for reimbursement of rent constituting property tax paid; i.e., low-income and elderly or disabled who rent property as opposed to owning it.
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:
There are no costs that are incurred as a result of the rules.
 - Qualitative description of impact:
Having the guidance from the rules will benefit potential applicants by helping them understand some of the eligibility parameters and other program specifics. The rules also help program staff understand how the program is to be administered.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
None beyond those necessitated by the underlying statute.

- Anticipated effect on state revenues:
No impact.

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

Eliminating the rules altogether could lead to confusion and result in the need for staff to seek legal guidance.

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

The Policy Manual may be more accessible to potential claimants who have access to the internet. However, the rule contains information that is more applicable at the programmatic level rather than the claimant level.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
None.

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

Iowa Code section 425.37 specifies that the Department shall adopt rules, particularly around preventing duplication of benefits with the property tax credit as well as preventing any undue hardships on applicants. The rules apply at the programmatic level as opposed to the claimant level, so it would not be appropriate to put that information in a Policy Manual.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 62 and adopt the following **new** chapter in lieu thereof:

CHAPTER 62 RENT REIMBURSEMENT

441—62.1(425) Eligible claimants. This rule is effective for rent reimbursement claims received by the department on or after January 1, 2023.

This rule is intended to implement Iowa Code section 425.16(2) “b.”

441—62.2(425) Dual claims.

62.2(1) A claimant changing homesteads during the base year who will make property tax payments during the fiscal year following the base year and who also made rent payments during the base year is entitled to receive both a property tax credit and rent reimbursement.

62.2(2) Claimants must file separate claim forms for the property tax credit and the rent reimbursement with the county treasurer and the department, respectively.

62.2(3) The claims are to be based on the actual property tax due and rent constituting property tax paid, with a combined maximum of \$1,000 upon which the credit and reimbursement can be calculated.

EXAMPLE: \$800 property tax due

\$400 rent constituting property taxes paid

- a. The claim form for calculating the property tax credit must reflect the entire \$800 amount.
- b. The claim form for calculating the rent reimbursement must reflect only the remaining \$200 of the \$1,000 maximum allowance.
- c. The department will issue refund warrants for rent reimbursement claims. The county treasurer will apply the credit.

This rule is intended to implement Iowa Code section 425.24.

441—62.3(425) Multipurpose building.

62.3(1) A multipurpose building is a building which is used for other purposes in addition to being used for living accommodations. If a portion of a homestead property is utilized for business purposes, the property is considered to be a multipurpose building.

62.3(2) The portion of the property tax due or rent constituting property tax paid attributable to the homestead only is to be used in determining the allowable credit or reimbursement. This portion is to be calculated by determining the percentage of the homestead square footage to the square footage of the entire multipurpose structure. This percentage is then to be applied to the property tax due in the current fiscal year or rent constituting property tax paid for the base year.

This rule is intended to implement Iowa Code section 425.17(8).

441—62.4(425) Income.

62.4(1) Income includes the amount of in-kind assistance received by the claimant for housing expenses such as federal rent subsidy payments made directly to the landlord on behalf of the claimant and energy assistance benefits received by the claimant from or through a public utility.

62.4(2) In determining income, net operating losses and net capital losses are not to be considered. If the comparison of gains and losses results in a net gain, such amount shall be considered income. If the comparison results in a net loss, the net loss shall be disregarded.

This rule is intended to implement Iowa Code section 425.17(7).

441—62.5(425) Simultaneous homesteads. A person who rents one property and also rents another property for a simultaneous period of time is limited to claiming rent reimbursement on the property that is considered the person's domicile.

This rule is intended to implement Iowa Code section 425.17(4).

441—62.6(425) Mobile, modular, and manufactured homes. Rent paid by an eligible claimant for occupancy of a mobile, modular, or manufactured home subject to the annual tax as provided in Iowa Code chapter 435 is subject to reimbursement regardless of how the home is taxed.

This rule is intended to implement Iowa Code section 425.17(4).

441—62.7(425) Totally disabled.

62.7(1) A claimant is considered totally disabled only if the physical or mental impairment or impairments are of such severity that the claimant is not only unable to do work previously performed but cannot, considering the claimant's age, education, and work experience, engage in any other kind

of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which the claimant lives, or whether a specific job vacancy exists, or whether the claimant would be hired if the claimant applied for work.

62.7(2) For purposes of this rule, a person shall not be considered unable to engage in substantial gainful employment unless the person has attained the age of 18 on or before December 31 of the base year.

This rule is intended to implement Iowa Code section 425.17(11).

441—62.8(425) Household. “Household” includes the claimant and the claimant’s spouse if living with the claimant at any time during the base year. “Living with” does not include a temporary visit. Only one claimant per household is entitled to a reimbursement.

This rule is intended to implement Iowa Code sections 425.17(5) and 425.22.

441—62.9(425) Homestead. A person who owns a homestead but is confined to a care facility shall be considered as occupying the owned homestead provided the person does not lease or otherwise receive profits from others for the use of the homestead. The person shall be eligible for a property tax credit but shall not be eligible for a rent reimbursement.

This rule is intended to implement Iowa Code section 425.17(4).

441—62.10(425) Gross rent/rent constituting property taxes paid. “Gross rent” means the total amount of rent paid for use of the homestead by the claimant.

This rule is intended to implement Iowa Code section 425.17(3).

441—62.11(425) Leased land. An individual who owns a dwelling located on land owned by another may claim a credit of property taxes due on the dwelling and a reimbursement of rental payments made for the use of the land if the land has been assessed for taxation.

This rule is intended to implement Iowa Code section 425.17(4).

441—62.12(425) Property: taxable status. If the property was taxable for only part of the base year, the rent reimbursement must be prorated accordingly (OP.ST. BD. Tax Rev. 187). However, this restriction does not apply to property that became tax exempt on or after July 1, 1986, provided the claimant received a reimbursement of rent constituting property taxes paid on the property when it was in a taxable status and continues to reside in the same property.

This rule is intended to implement Iowa Code section 425.17(4).

441—62.13(425) Income: spouse. The income of a spouse does not have to be reported on the claimant’s return unless the spouse lived with the claimant at the property upon which rent reimbursement is claimed. If the spouse lived with the claimant for only a portion of the base year, only that portion of the spouse’s income which was received while living with the claimant must be reported as income on the claimant’s return. If the spouse is eligible to claim reimbursement, the spouse does not have to include any income that was reported on the other claimant’s (spouse’s) return.

This rule is intended to implement Iowa Code section 425.17(6).

441—62.14(425) Common law marriage.

62.14(1) A common law marriage is a social relationship between two persons that meets all the necessary requisites of a marriage except that it was not solemnized, performed, or witnessed by an official authorized by law to perform marriages.

62.14(2) The necessary elements of a common law marriage are:

- a. A present intent of both parties freely given to become married,
- b. A public declaration by the parties or a holding out to the public that they are spouses,
- c. Continuous cohabitation together as spouses (this means consummation of the marriage), and

d. Capability of both parties to enter into the marriage relationship.

62.14(3) No special time limit is necessary to establish a common law marriage.

This rule is intended to implement Iowa Code section 425.17.

441—62.15(425) Audit of claim.

62.15(1) *Authority.* The department may investigate the eligibility of a claimant for rent reimbursement.

62.15(2) *Recomputed rent reimbursement claim.* If the department determines a computed rent reimbursement is in error, the department shall collect any overpayment from the claimant or reimburse the claimant for any underpayment. If a claimant fails to reimburse the department for an overpayment, the amount of overpayment shall be deducted from any future rent reimbursement to which the claimant is entitled.

This rule is intended to implement Iowa Code section 425.27.

441—62.16(425) Extension of time for filing a claim. The granting of an extension of time for filing a claim for reimbursement does not extend the time within which or the dates on or by which eligibility requirements must be satisfied.

This rule is intended to implement Iowa Code section 425.20.

441—62.17(425) Proration of claims. If the director or the director's designee determines that the amount of funding provided pursuant to Iowa Code section 425.39 will be insufficient to pay all rent reimbursement claims filed, the director or the director's designee will estimate the percentage at which the claims will be paid and will prorate the payment of each rent reimbursement claim by the same estimated percentage.

This rule is intended to implement Iowa Code sections 25B.7 and 425.39.

441—62.18(425) Unreasonable hardship. In order to avoid any unreasonable hardship to a claimant, the director or the director's designee may review the facts and circumstances of the claim as set forth by the claimant. The director or the director's designee may investigate all factors related to the specific case as deemed appropriate by the director or the director's designee. If the director or the director's designee is satisfied that the claim qualifies as an undue hardship for the claimant, the claim will be approved by the director or the director's designee.

This rule is intended to implement Iowa Code section 425.37.

441—62.19(425) Appeal. Notice of adverse action taken by the department shall be issued in accordance with 441—Chapter 16, and the right to appeal shall be given in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 17A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 65
“Supplemental Nutrition Assistance Program Administration”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 234.6 and 217.6

State or federal law(s) implemented by the rulemaking: Iowa Code section 234; H.R.2. Agriculture Improvement Act of 2018; Food and Nutrition Act of 2008; 7 U.S.C. 2011 et seq. as amended through Public Law (PL) 115-334, enacted December 20, 2018; 7 CFR 271, 272, 273, 274; Title VI Appendix, pg. 275; PL 107-171; PL 102-237; and PL 99-603

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The Supplemental Nutrition Assistance Program (SNAP) provides food benefits to eligible low-income families to supplement their food budget. This proposed chapter is intended to structure, simplify, and provide familiarity with the Department’s implementation of SNAP.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who are eligible for, or have an interest in, SNAP benefits will benefit.
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:
The Department incurs personnel costs for team members to implement the program. The costs of SNAP benefits are paid for by the federal government. The costs to administer SNAP are split between the state and the federal governments. So far in 2024, the Department is issuing on average \$44,127,783 per month in SNAP benefits. These rules have been used to implement SNAP in Iowa for more than 300,000 Iowans.

- Qualitative description of impact:

These rules will benefit clients by providing program clarity and consistency.

3. Costs to the State:

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

No additional costs are anticipated beyond those appropriated.

- Anticipated effect on state revenues:

No impact is anticipated on state revenues.

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

Eliminating these rules entirely could lead to confusion, lack of available information for this population, and lack of program clarity.

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

None were identified.

6. Alternative methods considered by the agency:

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

No alternative methods were seriously considered.

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

Alternatives, such as the primary point of reference being state plans for SNAP Employment and Training (E&T) and SNAP, would be subject to constant revision and would cause inconsistencies and lack of clarity for the program. This chapter clarifies federal regulations and establishes a legal basis for Iowa's administrative options.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 65 and adopt the following **new** chapter in lieu thereof:

FOOD PROGRAMS

TITLE VII

CHAPTER 65

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM ADMINISTRATION

441—65.1(234) Definitions.

“Notice of expiration” means a message printed on a form prescribed by the department, which is automatically issued to the household.

“Supplemental Nutrition Assistance Program” or *“SNAP”* means benefits provided by the federal program administered through 7 CFR Parts 270 through 283 (May 2, 2022).

441—65.2(234) Administration of program. SNAP will be administered in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq.; 7 CFR Parts 270 through 283 (May 2, 2022); PL 99-603; PL 104-193; PL 107-171; and with 42 U.S.C. Chapter 7 (January 7, 2011). A copy of the federal law and regulations may be obtained at no more than the actual cost of reproduction by contacting the department.

441—65.3(234) State options. The state of Iowa has selected SNAP state options that are tailored to meet the state’s operational considerations and policy preferences. These options can be viewed on the U.S Department of Agriculture website under the State Options Report.

441—65.4(234) Treatment centers and group living arrangements. Substance use treatment or rehabilitation centers and group living arrangements shall provide a list of participating residents to the department on a monthly basis.

441—65.5(234) Appeals. Fair hearings and appeals are provided according to 441—Chapter 7.

441—65.6(234) Proration of benefits. Benefits will be prorated using a 30-day month.

441—65.7(234) Notice of expiration issuance. Issuance of the automated Notice of Expiration will occur with the mailing of a form prescribed by the department.

441—65.8(234) Verification. Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a face-to-face interview and additional documentation requirements in accordance with 481—Chapter 72.

Failure to cooperate with the investigations division of the department of inspections, appeals, and licensing in establishing eligibility factors will not result in denial or cancellation of the household’s SNAP benefits. The investigations division will gather as much information as possible without the client’s cooperation. If further information is needed based on those findings, a request for information must be sent to the household.

441—65.9(234) Prospective budgeting.

65.9(1) Weekly or biweekly income. The department will convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program (FIP) procedures.

65.9(2) Income averaging. The department will average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

441—65.10(234) Effective date of change. A SNAP change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

441—65.11(234) Work requirements. As a condition of eligibility for SNAP benefits, each nonexempt household member must comply with SNAP work requirements.

65.11(1) Deregistration. Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.11(2) Employment and training (E&T) program. The department will design and operate an employment and training program with the purpose of providing SNAP participants opportunities to

gain skills, training, work, or experience that will increase their ability to obtain regular employment and meet state or local workforce needs in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq.

- a. The employment and training program serves individuals who are:
 - (1) SNAP recipients or SNAP applicants.
 - (2) Not receiving FIP assistance or other cash assistance under Title IV such as Tribal Temporary Assistance for Needy Families (TANF) or Refugee Cash Assistance.
 - (3) Physically and mentally able to work or will be able to work within the next one year.
 - b. The department or its designee shall serve as the provider of employment and training services for SNAP recipients who wish to volunteer, except for those who are also recipients of FIP benefits. Federal law prohibits FIP recipients from participating in any SNAP E&T program.
 - c. The program offers a range of services from basic skills to advanced occupational training in order to accommodate persons with various levels of need and abilities. The department or its designee may require a potential E&T participant to engage in aptitude or vocational testing activities when deemed necessary to determine if a component is appropriate for improving employability.
 - d. The E&T program will be designed in consultation with the state workforce development board or with private employers or employer organizations if the department determines the latter approach is more effective and efficient.
 - (1) The E&T program will be designed to include case management services and at least one or more or a combination of employment and training components.
 - (2) An E&T plan will be submitted to the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture annually, in accordance with 7 CFR 273.7(c)(6) (May 2, 2022), and will be amended as necessary within the required time frame prior to implementation.

441—65.12(234) Income. In determining eligibility, the department will exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans' educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. §1396 2011 et seq.) for the state's modified adjusted gross income (MAGI)-related medical assistance program, subject to subrule 65.12(4).

65.12(1) Notwithstanding anything to the contrary in these rules or regulations, the department will exclude educational income based on amounts earmarked by the institution, school, program, or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation, and miscellaneous personal expenses (other than living expenses).

65.12(2) If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students will receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

65.12(3) For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.12(4) Certain types of student income will be treated as follows, regardless of how they are considered for MAGI-related medical assistance.

- a. Wages are not excluded.
- b. Federally funded work study is excluded.
- c. State-funded work study is excluded up to the amount earmarked for educational expenses.

441—65.13(234) Deductions. A household in which all members are homeless may choose the homeless standard deduction in place of the shelter and utility expenses deduction.

65.13(1) Households choosing this option are not required to verify shelter-related expenses.

65.13(2) Households choosing this option are not eligible to receive a shelter or utility deduction.

65.13(3) The amount of the homeless standard deduction is determined by the FNS and adjusted annually.

441—65.14(234) Student resources. Any income excluded by rule 441—65.12(234) will be excluded from resources.

441—65.15(234) Reinstatement. When assistance has been canceled for failure to provide requested information, assistance will be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date all information required to establish eligibility is provided.

These rules are intended to implement Iowa Code sections 234.12 and 234.6.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 66
“Emergency Food Assistance Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 234.6

State or federal law(s) implemented by the rulemaking: Iowa Code section 234.12 and 7 CFR Parts 251 and 250

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter sets forth household eligibility criteria for The Emergency Food Assistance Program (TEFAP) in Iowa.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Clients seeking emergency food assistance will benefit.
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:
There would not be a significant cost. The Department incurs personnel costs for the program. For state fiscal year 2023, an estimated 88,522 Iowa households received TEFAP foods.
 - Qualitative description of impact:
These rules play an important role in providing clarity, consistency, and a legal basis for decisions made by the Department.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
The Department incurs personnel costs to execute the program.

- Anticipated effect on state revenues:
No effect on state revenues is anticipated beyond those already appropriated.
- 4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:
The absence of these rules could lead to lack of clarity or lack of clear legal authority.
- 5. Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:
A less costly method has not been identified to achieve the purpose of this chapter.
- 6. Alternative methods considered by the agency:
 - Description of any alternative methods that were seriously considered by the agency:
Much of the benefit is achieved through contract and internal documents. These portions of the chapter have been removed.
 - Reasons why alternative methods were rejected in favor of the proposed rulemaking:
The household eligibility rules provide clarity, consistency, and a legal basis for decisions made by the Department.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 66 and adopt the following **new** chapter in lieu thereof:

CHAPTER 66 EMERGENCY FOOD ASSISTANCE PROGRAM

441—66.1(234) Definitions.

“*Household*” means a single individual living alone or a group of related or nonrelated individuals who live together, who are not boarders or residents of an institution, and who purchase and prepare food for home consumption.

“*TEFAP*” means The Emergency Food Assistance Program as authorized by the Emergency Food Assistance Act of 1983 as amended through PL 107-249, enacted October 23, 2002.

441—66.2(234) Household eligibility. Household eligibility is determined by residence, household size, and income.

66.2(1) Residence. Household members must be residing in the state of Iowa.

66.2(2) *Household size.* Household size is determined by the number of people living in a dwelling, excluding boarders, as household is defined in rule 441—66.1(234).

66.2(3) *Income eligibility.* All earned and unearned income of the household must be considered in determining eligibility.

a. Income defined. Income means all income received by an individual from sources identified by the U.S. Census Bureau in computing median income and includes:

- (1) Money wages or salary;
- (2) Net income from nonfarm self-employment;
- (3) Net income from farm self-employment;
- (4) Dividends;
- (5) Interest;
- (6) Income from estates or trusts;
- (7) Net rental income and royalties;
- (8) Public assistance or welfare payments;
- (9) Pensions and annuities;
- (10) Workers' compensation;
- (11) Alimony;
- (12) Child support;
- (13) Veterans' pensions;
- (14) Social security;
- (15) Railroad retirement;
- (16) Supplemental security income;
- (17) State or federal assistance;
- (18) Veterans' benefits;
- (19) Black lung benefits;
- (20) All disability pensions;
- (21) State supplementary assistance;
- (22) Unemployment compensation benefits; and
- (23) Income from minors under 16 years of age.

b. Determination of income. Earned or unearned income is the gross annual, monthly, or weekly income.

- (1) Biweekly income is to be multiplied by 2.15 to determine monthly income.
- (2) Adjusted gross self-employment income will be averaged over a 12-month period.
- (3) Income received from interest and dividends will be averaged over a 12-month period.
- (4) The amount of income that stops or starts during the month will be estimated based on the best information available.

c. Income exclusions. When calculating total household income for this program, all income must be excluded that is specifically excluded for food assistance by federal statute, especially those sources listed in federal regulations at 7 CFR 273.9(c)(10) as amended to May 2, 2022.

d. Income guidelines. Households are eligible for TEFAP when the countable household income is at or below 185 percent of the federal poverty guidelines. These federal guidelines are revised annually, effective every July 1.

These rules are intended to implement Iowa Code sections 234.6 and 234.12.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 67
“Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 234.6(1)“f”

State or federal law(s) implemented by the rulemaking: 42 U.S.C. §1786 and 7 CFR 246

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@idph.iowa.gov

Purpose and Summary

The WIC program must follow USDA regulations. States do have some flexibility in how some of the federal regulations are implemented—the Iowa Administrative Code can provide more Iowa-specific practices; however, the USDA regulations would take precedence.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who are eligible for, or have interest in, the WIC program and contracting agencies and vendors will benefit.
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:
None were identified.
 - Qualitative description of impact:
These rules benefit clients, contracting agencies, and vendors by providing clarity and consistency.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
No additional costs are anticipated beyond those appropriated.

- Anticipated effect on state revenues:

No impact is anticipated.

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

Eliminating these rules entirely could lead to confusion; lack of available information for clients, contracting agencies and vendors; and lack of program clarity.

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

None were identified.

6. Alternative methods considered by the agency:

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

No alternative methods were seriously considered.

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

Alternatives, such as the sole reference point being a state plan, may cause inconsistencies or lack of clarity. In addition, this chapter clarifies federal regulations and establishes a legal basis for Iowa's administrative options.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Adopt the following **new**441—Chapter 67:

CHAPTER 67 SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

441—67.1(135) Definitions. Definitions can be found in 7 CFR Part 246 (as amended to August 1, 2024) and state-specific definitions can be found in Iowa WIC policies and procedures. Iowa WIC policies and procedures describe the manner in which the department implements and operates all aspects of program administration within its jurisdiction in accordance with 7 CFR Part 246 (as amended to August 1, 2024), USDA policy memorandums, USDA guidance documents, and any other documents issued by USDA to implement the WIC program.

441—67.2(135) Administration of program. The Iowa department of health and human services implements the WIC program by following guidance from 7 CFR Part 246 (as amended to August 1, 2024), United States Department of Agriculture (USDA) policy memos, USDA guidance documents, and any other documents issued by USDA to implement the WIC program.

441—67.3(135) Certification of participants. Eligibility will be determined pursuant to 7 CFR 246.7 (as amended to August 1, 2024), any USDA-issued documents used to implement the WIC program, and the WIC Policy and Procedure Manual.

441—67.4(135) Food delivery.

67.4(1) *Responsibilities of department—approving or denying applications.* The department will determine if applications meet mandatory specifications and may deny an application pursuant to 7 CFR 246 (as amended to August 1, 2024), USDA federal regulations, USDA guidance documents, or the Iowa WIC Program Vendor Guidance, Iowa WIC Program Vendor Application, and the Iowa WIC Program Vendor Handbook and Agreement.

67.4(2) *Responsibilities of WIC vendors.*

a. A potential vendor shall make application to the department of health and human services WIC program and shall accept the obligations imposed by the signing of the Iowa WIC Program Vendor Agreement and Handbook prior to acceptance of any WIC food instrument. To qualify as a WIC vendor, the vendor shall meet all of the criteria outlined in the Iowa WIC Program Vendor Guidance, Iowa WIC Program Vendor Application, and Iowa WIC Program Vendor Agreement and Handbook.

b. The vendor must agree to adhere to all provisions of the Iowa WIC Program Vendor Application, Iowa WIC Program Vendor Agreement and Handbook, Iowa WIC Program Vendor Guidance.

67.4(3) *Criteria for approving products for inclusion in the WIC food package.*

a. A product shall meet the federal regulations governing the WIC food package.

b. If a vendor offers specialty eggs for retail sale, the vendor shall maintain an inventory of conventional eggs for retail sale sufficient to meet federal and state requirements for participation in the WIC program.

c. Products will be evaluated for use in the Iowa WIC program based on nutrient content, packaging, container size, labeling, availability to wholesale distributors, cost, and participant preference. The state reserves the right to limit the number of foods, infant formulas, exempt infant formulas, and WIC-eligible nutritional products for the WIC-approved food list based on accessibility, availability, retail value of product, USDA recommendations, increased number of WIC participants, changes in appropriation of funds and administrative efficiency.

d. The approved food list provides more specifics on what is allowed or not allowed for each of the WIC-approved foods.

e. In addition to the criteria specified above, the department reserves the right to make changes to the criteria or further restrict the number and types of brands of any products in order to contain the cost of the food package through competitive procurement of rebate contracts or other similar means.

f. The department reserves the right to discontinue specific brand names and products if the cost is administratively burdensome for that particular product.

g. The department reserves the right to add or delete products pursuant to federal regulations.

441—67.5(135) Education.

67.5(1) Participants who are high risk, as defined in the Iowa WIC Policy and Procedure Manual, shall be seen by a licensed dietitian as described in the Iowa WIC Policy and Procedure Manual with a care plan developed as described in the Iowa WIC Policy and Procedure Manual.

67.5(2) To the extent that time and resources are available, nutrition education may be provided to applicants who are not eligible to receive other WIC services.

441—67.6(135) Right to appeal—participant. Fair hearings and appeals are provided pursuant to 441—Chapter 7 and 7 CFR §246.9 (as amended to August 1, 2024).

441—67.7(135) Right to appeal—local agencies. Fair hearings and appeals are provided pursuant to 441—Chapter 7, 7 CFR §246.18 (as amended to August 1, 2024), and 7 CFR §246.24 (as amended to August 1, 2024).

441—67.8(135) Right to appeal—vendor. Fair hearings and appeals are provided pursuant to 441—Chapter 7, 7 CFR §246.12 (as amended to August 1, 2024), and 7 CFR §246.18 (as amended to August 1, 2024).

441—67.9(135) State monitoring of contract agencies. At minimum, one of the persons from the department responsible for reviewing a contract agency shall be a licensed dietitian.

441—67.10(135) Civil rights. The Iowa WIC program shall operate in compliance with state and federal regulations and FNS Instruction 113-1 to ensure the rights of all individuals under the WIC program.

441—67.11(135) WIC program violation. Participants or vendors are subject to the sanctions outlined below if determined by contract agency or department staff to be guilty of abusing the WIC program or its regulations.

67.11(1) Participant violation. Violations may be reported by contract agency staff, vendors, the public, FNS staff, or department staff. All suspected cases of fraud will be investigated by the department. All sanctions will be administered by the department. Contract agencies will be notified of any actions taken against WIC participants by the department.

a. Whenever possible, the participant is contacted via telephone concerning the violation. Documentation is maintained according to procedures set forth in the Iowa WIC Policy and Procedure Manual.

b. Participants who violate WIC program regulations are subject to sanction in accordance with the schedule below:

Violation	Sanction Action
1. Intentional false statement(s) or misrepresentation of income, name, residence, family size (including receiving and using benefits for children no longer in the family), medical data, pregnancy, and/or date of birth to obtain WIC benefits.	One-year disqualification and pay full restitution
2. Return of WIC foods to vendor for unapproved food items, nonfood items, credit or cash (attempted or actual). Claim amount less than \$100.	Two-month disqualification and pay full restitution
Buy, trade, exchange, transfer, sell, or offer to buy, trade, exchange, transfer, sell, or allow any other person to buy, trade, exchange, transfer, sell or offer to buy, trade, exchange, transfer or sell eWIC card/ benefits for unapproved food items, nonfood	Subsequent violation of any claim amount: one-year disqualification and pay full restitution

- items, cash or favors. Claim amount less than \$100.
3. Return of WIC foods to vendor for unapproved food items, nonfood items, credit or cash (attempted or actual). Claim amount greater than \$100.

Buy, trade, exchange, transfer, sell, or offer to buy, trade, exchange, transfer, sell or allow any other person to buy, trade, exchange, transfer, sell or offer to buy, trade, exchange, transfer, or sell WIC foods for unapproved food items, nonfood items, cash or favors. Claim amount greater than \$100.
 4. Creating a public nuisance or disrupting normal activities through verbal misconduct or physical disruptions at the local WIC agency, farmers market, or vendor location.

First violation: Education/counseling
Second subsequent violation: Warning letter
Third subsequent violation: Two-month disqualification
Fourth subsequent violation: Any subsequent violation(s) will result in a one-year disqualification.
Two-month disqualification
Subsequent violation will result in a one-year disqualification.
 5. Verbal abuse or harassment of WIC staff, vendors, farmers market vendors and/or other WIC participants. This includes verbal abuse or harassment in person, on social media, or over the telephone.
 6. Physical abuse (directly or indirectly carrying out the actual harm or threatening to do harm) of WIC staff, vendors, vendor staff, farmers market vendors, farmers market vendor staff, and/or other WIC participants.

Any violation will result in a one-year disqualification.
 7. Destruction of property, theft of eWIC card(s) or theft from a local WIC agency, vendor, vendor staff, farmers market vendor, farmers market vendor staff, and/or another WIC participant.

Any violation will result in a one-year disqualification.
 8. Collusion with staff to improperly obtain benefits.

One-year disqualification and pay full restitution
 9. Dual participation resulting from intentional misrepresentation.

One-year disqualification and pay full restitution
 10. Trafficking WIC food benefits, WIC benefits, or WIC items and/or collusion with an authorized vendor.

One-year disqualification and pay full restitution
 11. Other violations of this chapter or the Iowa WIC Policy and Procedure Manual.

As appropriate per this chapter or the Iowa WIC Policy and Procedure Manual
- c. Local law enforcement may be notified in appropriate cases.

d. Fifteen days' notice must be given prior to all disqualifications. In all cases, the participant must be informed of the reason for the disqualification, of the right to appeal the decision through the fair hearing process, and of eligibility to receive WIC services at the end of the disqualification period.

e. A disqualification may apply to all members of a family who are on the WIC program.

f. Violations are cumulative. However, a participant will not have sanctions assessed for committing a second violation when the second violation occurs before the participant receives notice of the first violation and the second violation is the same as the first. A participant who commits the same violation a second time following receipt of a notice for the first violation is subject to a one-year disqualification.

g. When a participant improperly received benefits as a result of intentionally making a false or misleading statement(s) or intentionally misrepresenting, concealing, or withholding facts or sells or attempts to sell benefits the participant received from the WIC program and is disqualified from the WIC program, the participant may be required to make restitution of the cash value of the improperly received or used WIC benefits. The department may establish a claim against the participant for the full value of the improperly received benefits.

The department will issue a written notice of restitution and disqualification.

If the participant chooses a repayment plan for claims, the department will assist in developing a payment schedule. If the participant has not paid the department directly within 30 days of the notice of restitution and disqualification, the department will pursue collection of the dollar amount owed and benefits will be discontinued until the claim is paid.

h. The department may decide not to impose a mandatory disqualification pursuant to 7 CFR §246.12(u)(2) (as amended to August 1, 2024). All decisions are at the discretion of the department.

i. When a disqualification period has ended, the individual disqualified may be reinstated if the individual's certification period is still current. If the individual's certification period is not current, the individual will need to complete a certification appointment.

j. The department will maintain a master list of all participant violation notices, disqualifications, and statements of restitution. The participant's notice of violation must also indicate when it is a second offense.

67.11(2) *Vendor violations.* There are five types of sanctions that are applied to vendors for violations of WIC program regulations: nonpayment of food instruments, issuance of violation points, temporary disqualification, permanent disqualification, and civil money penalties (CMPs).

a. Nonpayment of food instruments. If the vendor has been terminated from the WIC program and submits a claim, it will be fully denied.

b. Administrative and procedural violation points. Administrative and procedural violations are offenses to the provisions of the Iowa WIC Vendor Agreement and Handbook that do not rise to the level of fraud against the WIC program or its participants.

These violations are an indication of a vendor's inattention to or disregard of the requirements of the WIC vendor agreement. It is in the department's interest to record and consider these violations when considering whether to continue its contractual relationship with the vendor.

One or more transactions prior to notification of the vendor constitute only one violation if they contain the same error.

The assignment of violation points does not limit the department's right to effect stronger penalties and sanctions in cases in which there is evidence of an intentional or systematic practice of abusing or defrauding the Iowa WIC program.

Violation	Points Per Event
1. Developing and using promotional materials including stickers, tags, labels, or channel strips with the WIC service mark to identify WIC-approved foods.	5
2. Developing and using vendor-created WIC vendor identification decals to indicate vendor is an authorized vendor.	5

Violation	Points Per Event
3. Failure to allow WIC participants to leave the vendor with WIC foods that were debited/removed from their eWIC account during a WIC transaction.	5
4. Failure to post eWIC signs in the cash register lane that has a working WIC terminal if the vendor is not integrated.	5
5. Failure to provide vendor ECR system participant receipts to WIC participants during each WIC transaction.	5
6. Failure to reimburse department for potentially overpaid food instrument or provide reasonable explanation for the cost of the food instrument.	10
7. Refusal to accept valid WIC food instruments from participants.	10
8. Discriminatory treatment of WIC participants, such as requiring WIC participants to use special checkout lanes or provide extra identification, or disallowing the use of coupons or other vendor discounts in WIC transactions that are allowed in non-WIC transactions.	10
9. Treating WIC customers differently by offering them incentive items, vendor discounts, coupons, or other promotions that are not offered to non-WIC customers.	10
10. Providing to WIC participants incentive items not prior authorized by the department.	10
11. Failure to carry out corrective action plan developed as a result of monitoring visit.	10
12. Accepting the return of food purchased with WIC food instruments for cash or credit toward other purchases.	10
13. Issuing "rain checks" or credit in exchange for WIC food instruments.	10
14. Stocking out-of-date, stale, or moldy WIC foods.	10
15. Failure to submit vendor price assessment reports as requested.	10
16. Failure to train all employees and ensure their knowledge regarding WIC program procedures set forth in the vendor's current agreement and in the current publication of the Iowa WIC program's vendor instruction booklet.	10
17. Requiring WIC participants to purchase a particular brand when other WIC-approved brands are available.	10
18. Not allowing WIC participants to use discount coupons or promotional specials to reduce the WIC food instrument amount.	10
19. Requiring to enter the PIN for the participant and/or asking for the participant's PIN.	10
20. For vendors that have special WIC prices, failure to post WIC prices on the shelf or on the package.	15
21. Contacting WIC participants in an attempt to recover funds not paid by WIC.	15
22. Providing false information on the price assessment report.	15
23. Knowingly entering false information or altering information on the eWIC receipt/benefits.	10
24. Requiring other cash purchases to redeem WIC food instruments.	15

Violation	Points Per Event
25. Failure to obtain infant and/or special needs formula from an approved source listed by the Iowa WIC program.	15
26. Offering incentive items with a value of more than \$1.99.	15
27. Scanning any UPC code that is not affixed to the actual item being purchased by the WIC participant.	20
28. Failure to allow purchase of up to the full amount of WIC foods authorized on the food instrument if such foods are available and desired by the WIC participant.	20
29. Failure to maintain minimum stocking requirements.	10
30. Other violations of this chapter or the Iowa WIC Program Vendor Agreement and Handbook or the Iowa WIC Policy and Procedure Manual.	As appropriate per this chapter, the Iowa WIC Program Vendor Agreement and Handout or the Iowa WIC Policy and Procedure Manual

c. One-year disqualification. With an administrative finding of the following patterns of sanctions, the vendor will be disqualified for one year.

(1) A pattern of allowing purchase of nonapproved food items in exchange for WIC food instruments or for foods provided in excess of those listed on the WIC food instrument. (federally mandated sanction)

(2) Accumulation of 45 or more violations points within a single federal fiscal year of the agreement period. (department sanction)

(3) Failure to provide access to vendor premises or in any manner to hinder, impede or misinform authorized WIC personnel in the act of conducting an on-site education, monitoring or investigation visit. (department sanction)

(4) Loss of department of inspections, appeals, and licensing license. (department sanction)

(5) Submitting for payment a WIC food instrument redeemed by another authorized vendor. (department sanction)

(6) Threatening or verbally abusing WIC participants or authorized WIC program personnel in the conduct of legitimate WIC program transactions. (department sanction)

(7) Submitting for payment WIC food instruments known by the vendor to have been lost or stolen. (department sanction)

(8) Participating with other individuals, including but not limited to WIC employees, vendors, and participants, in systematic efforts to submit false claims for reimbursement of improper WIC food instrument. (department sanction)

d. A vendor will be disqualified from being a WIC vendor for three years with an administrative finding of any violation detailed in 7 CFR §246.12(l)(iii) (as amended to August 1, 2024).

e. A vendor will be disqualified from being a WIC vendor for six years pursuant to 7 CFR §246.12(l)(1)(ii) (as amended to August 1, 2024).

f. The department will impose mandatory vendor sanctions pursuant to 7 CFR §246.12(l)(1)(i) (as amended to August 1, 2024).

g. The following does not have a point value, but shall result in or extend a disqualification period:

For each month in which a vendor accepts WIC food instruments during a disqualification period, the disqualification period shall be extended by 30 days.

h. The above sanctions notwithstanding, the state of Iowa reserves the right to seek civil and criminal prosecution of WIC vendors for any and all instances of dealing in stolen or lost food instruments, trading cash and other inappropriate commodities for food instruments, or cases in which there exists evidence of a clear business practice to improperly obtain WIC funds, or other practices meeting the definition of fraud as defined in 7 CFR Part 246 (as amended to August 1, 2024) or the Iowa Code.

i. A vendor shall not be entitled to receive any compensation for revenues lost as a result of any temporary or permanent disqualification.

j. A minimum of 15 days' notice is provided prior to all disqualifications, except for permanent disqualifications assessed under paragraph 73.19(2) "*f*," which are effective on the date of receipt of the notice of administrative action. When the department determines that an offense has occurred, a disqualification letter with supporting documentation is prepared for the WIC director's signature. The disqualification letter identifies the specific offenses that the vendor is charged with and the procedures for filing an appeal. Voluntary withdrawal from the Iowa WIC Program Vendor Agreement and Handbook to avoid a sanction is not allowed.

k. The department is responsible for issuing all warning and disqualification letters. Contract agencies are informed of all vendor correspondence regarding violations. In situations where participant violations are also involved, the contract agency is responsible for follow-up, as detailed in subrule 73.19(1).

l. Disqualification from the WIC program may result in disqualification as a retailer in SNAP pursuant to 7 CFR §246.12(h)(3)(xxvi) (as amended to August 1, 2024), 7 CFR §246.18(b)(1) (as amended to August 1, 2024), and 7 CFR §246.12(l)(1)(xi) (as amended to August 1, 2024).

m. The department will disqualify a vendor who has been disqualified from SNAP pursuant to 7 CFR §246.12(l)(1)(vii) (as amended to August 1, 2024) and 7 CFR §246.12(l)(1)(ix) (as amended to August 1, 2024).

n. CMPs.

(1) When the department determines that a CMP shall be imposed in lieu of disqualification for reasons specified under paragraph 73.19(2) "*f*" or "*m*," it shall use the civil money penalty formula in accordance with 7 CFR §246.12(k)(1)(x) to determine the CMP.

(2) If a vendor does not pay, only partially pays, or fails to timely pay a CMP, the department will disqualify the vendor for the length of the disqualification corresponding to the violation for which the CMP was assessed. "Failure to timely pay a CMP" includes the failure to pay a CMP in accordance with an installment plan approved by the department.

(3) Money received by the state WIC agency as a result of CMPs or fines assessed against a vendor and any interest charged in the collection of these penalties and fines shall be considered as WIC program income.

These rules are intended to implement 42 U.S.C. §1786 and Iowa Code section 234.6(1).

Regulatory Analysis

Notice of Intended Action to be published: 441—78.11(249A)
“Amount, Duration and Scope of Medical and Remedial Services”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, House File 2397

Public Hearing

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

November 7, 2024
10 a.m.

Microsoft Teams
Meeting ID: 295 147 282 130
Passcode: jm6rgf

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this rulemaking is to implement 2024 Iowa Acts, House File 2397. The legislation creates new Iowa Code section 147A.19, which directs the Department to authorize payment for ambulance transport for persons experiencing a mental health crisis to mental health access centers in amounts similar to the payment for ambulance transport to a hospital emergency room.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans experiencing a mental health crisis who are transported by ambulance to a mental health access center will benefit.
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:
This service was not originally covered.
 - Qualitative description of impact:
This change will ensure timely treatment regarding the correct level of care for Iowa Medicaid members who are experiencing a mental health crisis.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

There is no cost impact on the agency.

- Anticipated effect on state revenues:

It was determined that a fiscal impact study was not possible due to the lack of data of Emergency Medical Services (EMS) providers transporting Iowa Medicaid members to mental health access centers.

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

Without this chapter, there would be no guidance on reimbursement to EMS providers for transports of Iowa Medicaid members to mental health access centers.

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

This is a less costly and less intrusive method for EMS providers to provide timely transport for Iowa Medicaid members to the appropriate level of care regarding mental health access centers.

6. Alternative methods considered by the agency:

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

No alternative methods were seriously considered.

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

There were no alternative methods.

Small Business Impact

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

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

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

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Amend rule 441—78.11(249A) as follows:

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home, ~~or to a nursing facility, or to a mental health access center.~~ Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) to 78.11(5) No change.

This rule is intended to implement Iowa Code section 249A.4.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 82
“Intermediate Care Facilities for Persons with an Intellectual Disability”

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

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A and 42 CFR 483

Public Hearing

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

November 7, 2024
10 a.m.

Microsoft Teams
Meeting ID: 295 147 282 130
Passcode: jm6rgf

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter provides operational and reimbursement rules for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/ID). These rules and the underlying federal regulations allow the Department to hold providers accountable and help ensure quality care for resident members on Medicaid.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Owners and operators of ICFs/ID and individuals residing in an ICF/ID will benefit.
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:
The impact is the reduction of redundant language in the chapter.
 - Qualitative description of impact:
Iowa currently has 74 facilities that are licensed as an ICF/ID. These rules and the underlying federal regulations allow the Department to hold providers accountable, help ensure quality care for resident members on Medicaid, and provide operational and reimbursement rules for ICFs/ID.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

There will be no new costs to the agency to enforce the chapter since no rate changes or system changes will occur.

- Anticipated effect on state revenues:

No effect on state revenues is anticipated.

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

The chapter is needed to provide information on reimbursement and quality standards for ICFs/ID in Iowa. Without regulation, quality of care and the health and well-being of residents could suffer.

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

Rulemaking is necessary to guide quality of care and provide consistency.

6. Alternative methods considered by the agency:

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

None were considered.

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

This type of information, in conjunction with the federal regulations, is appropriate to be contained in administrative rules.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 82 and adopt the following **new** chapter in lieu thereof:

CHAPTER 82 INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY

441—82.1(249A) Definitions.

“*Intermediate care facility for persons with an intellectual disability*” or “*ICF/ID*” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009 as amended to August 1, 2024; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermediate care facility for persons with medical complexity” means an intermediate care facility for persons with an intellectual disability that provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

“Managed care organization” 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.

This rule is intended to implement Iowa Code section 249A.12.

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections, appeals, and licensing pursuant to 481—Chapter 64. The facility shall meet the following conditions of participation.

82.2(1) Governing body and management—disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes that would affect the current accuracy of the information, as to identify:

- a. Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.
- b. Each officer and director of the corporation if the facility is organized as a corporation.
- c. Each partner if the facility is organized as a partnership.

82.2(2) Client protections. The facility shall ensure the rights of all clients in accordance with 42 CFR 483.420 as amended to August 1, 2024.

82.2(3) Facility staffing. The facility shall provide adequate, qualified professional staffing in accordance with 42 CFR 483.430 as amended to August 1, 2024.

82.2(4) Active treatment services. Each client shall receive a continuous active treatment program in accordance with 42 CFR 483.440 as amended to August 1, 2024.

82.2(5) Client behavior and facility practices. Each facility shall establish and maintain standards for client behavior and facility practices in accordance with 42 CFR 483.450 as amended to August 1, 2024.

82.2(6) Health care services. Each facility shall establish and maintain standards for health care services in accordance with 42 CFR 483.460 as amended to August 1, 2024.

82.2(7) Physical environment. Each facility shall establish and maintain standards for the physical environment in accordance with 42 CFR 483.470 as amended to August 1, 2024.

82.2(8) Dietetic services. Each facility shall establish and maintain standards for dietary services in accordance with 42 CFR 483.480 as amended to August 1, 2024.

This chapter is intended to implement Iowa Code section 249A.12.

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

This rule is intended to implement Iowa Code section 249A.12.

441—82.4(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a financial and statistical report to the department. These reports shall be based on the following rules.

82.4(1) *Failure to maintain records.* Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.4(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.4(3) *Submission of reports.* The facility's cost report shall be received by the department no later than September 30 each year except as described in subrule 82.4(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.4(3) "c."

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the department.

(2) The reduced rate shall 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 the department.

d. Amended reports. The department, in its sole discretion, may 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 submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.4(4) *Payment at new rate.* When a new rate is established, payment at the new rate will be effective with services rendered as of the first day of the month in which the report is postmarked, or if

the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments will be included in the payment the third month after the receipt of the report.

82.4(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses pertaining to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.4(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.4(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.4(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.4(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.4(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services that include room, board, nursing services, and such services as supervision, feeding, incontinence, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.4(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) 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 includes 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 the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation are unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, are required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.4(3) "c."

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions and depends upon the facts and circumstances of each case.

(3) 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.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators will be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained

in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.4(11) “e”(4) through 82.4(11) “e”(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit will 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 employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs are allowed only to the extent they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association’s Estimated Useful Lives of Depreciable Hospital Assets (2023 edition), may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment will be made. For change of ownership, refer to subrule 82.4(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider’s qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) 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.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that 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; that the services, facilities, or supplies are those that 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 that the charge to the facility 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, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

(1) When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report is the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return is defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

(2) When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report is limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

(3) The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility that supplies transportation services as defined in Iowa Code section 324A.1(1) shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, will result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Reserved.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.
- (4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.
- n. Penalties or fines imposed by federal or state agencies are not allowable expenses.
- o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.4(12) *Termination or change of owner:*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion but terminates with respect to the leased portion.

b. No increase in the value of the property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property are not allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

82.4(13) *Assessed fee.* The fee assessed pursuant to 441—Chapter 36 is not an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.4(14), not subject

to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.4(14) *Payment to new facility.* A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, is subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility will be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate will be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year. The state hospital schools are included in the compilation of facility costs. The beginning rates for a new facility will be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges that have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include but are not limited to legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(3) All facilities shall comply with the requirements of subrule 82.4(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.4(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate will be established for the facility. This rate will be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities will be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities that complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.4(14) "*d*," will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates will be subject to the prevailing maximum rate.

82.4(15) *Payment to new owner.* An existing facility with a new owner will continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.4(16). The facility may submit a report for the period of July 1 through June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.4(16) *Payment to existing facilities.* The following reimbursement limits apply to all non-state-owned ICFs/ID:

a. Each facility shall file a cost report covering the period from January 1, 1992, through June 30, 1992. This cost report will be used to establish a reimbursement rate to be paid to the facility and will be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 through June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, through June 30, 1992, will be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, through June 30, 1992, cost report will become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.4(14) “*d.*”

d. Facilities that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year will receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include but are not necessarily limited to the administrative portion of the following:

- (1) Administrator wages.
- (2) Business office wages.
- (3) Advertising and marketing wages.
- (4) Employer’s taxes (administrative).
- (5) Group/life and retirement benefits (administrative staff).
- (6) Workers’ compensation insurance (administrative staff).
- (7) Employment advertising and recruitment (administrative staff).
- (8) Criminal record checks (administrative staff).
- (9) Education and training (administrative staff).
- (10) Office supplies (administrative staff).
- (11) Telephone.
- (12) Equipment rental.
- (13) Home office costs.
- (14) Management fees.
- (15) Accounting fees.
- (16) Professional organization dues.
- (17) Licensing fees.
- (18) Information technology expenses.
- (19) Legal fees—direct patient-care-related.
- (20) Legal fees—other.
- (21) Working capital interest.
- (22) General liability insurance.
- (23) Travel, entertainment and auto expenses.
- (24) Advertising and public relations.
- (25) Other.

f. Facility rates will be rebased using the cost report for the year covering state fiscal year 1996 and will subsequently be rebased each four years. The department will consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.

(2) A change in federal regulations occurs that necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes that necessitate the addition of staff or other resources.

(3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).

(4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation are inpatient days as determined in subrule 82.4(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate will be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase that will not exceed the percentage change in the Consumer Price Index.

h. State-owned ICFs/ID shall submit semiannual cost reports and will receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

82.4(17) Wage add-on factor. A wage add-on factor of \$8.86 per day for community-based ICFs/ID will be included in rates effective July 1, 2022, and after, not subject to the maximum allowable cost ceiling in paragraph 82.4(14)"e," until rates are established using the cost reports for the period ending June 30, 2023.

a. In accordance with 2022 Iowa Acts, House File 2578, section 31, the entire wage add-on factor will be used for wages and associated costs specific to wages, benefits, and required withholding of direct support professionals and frontline management.

b. The wage add-on factor of \$8.86 per day will be added to the maximum allowable base rate in subparagraph 82.4(14)"d"(1) until the next rebase using cost reports for the period ending June 30, 2024.

c. The wage add-on factor of \$8.86 per day will be added to the maximum allowable cost ceiling, eightieth percentile of costs of all participating facilities in paragraph 82.4(14)"e," until the eightieth percentile maximum is established using the December 31, 2023, compilation for rates effective beginning July 1, 2024.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

441—82.5(249A) Eligibility for services.

82.5(1) Interdisciplinary team. The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.5(2) Evaluation. The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate

care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services that are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.5(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility will continue as long as a valid need for the care exists.

This rule is intended to implement Iowa Code section 249A.12.

441—82.6(249A) Initial approval for ICF/ID care.

82.6(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program will:

- a.* Identify appropriate service alternatives;
- b.* Inform the person of the alternatives; and
- c.* Refer a person without appropriate alternatives to the department.

82.6(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department will:

- (1) Approve ICF/ID placement;
- (2) Offer a home- or community-based alternative; or
- (3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.6(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.6(3) *Approval of level of care.* Medicaid payment will be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the department.

82.6(4) *Appeal rights.* Notice of adverse action and right to appeal will be given in accordance with 441—Chapter 7 and rule 441—16.3(17A).

This rule is intended to implement Iowa Code section 249A.12.

441—82.7(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay will be made according to procedures established by the department. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the client's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

441—82.8(249A) Arrangements with residents.

82.8(1) *Resident care agreement.* The ICF/ID Resident Care Agreement shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.8(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.8(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections, appeals, and licensing and will meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections, appeals, and licensing representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department will turn the funds over to the member's estate.

82.8(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

441—82.9(249A) Discharge and transfer.

82.9(1) Notice. When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.9(2) Case activity report. A case activity report shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.9(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.9(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician's or qualified intellectual disability professional's orders for care.
- f. The resident's personal records.
- g. When applicable, the personal needs fund record.

82.9(5) Income refund. When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

441—82.10(249A) Records.

82.10(1) Content. The facility shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections, appeals, and licensing.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act (as amended to August 1, 2024).

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records, which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

h. Resident accounts.

- i.* Inservice education program records.
- j.* Inspection reports pertaining to conformity with federal, state, and local laws.
- k.* Residents' personal records.
- l.* Residents' medical records.
- m.* Disaster preparedness reports.

82.10(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.10(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.11(249A) Payment procedures.

82.11(1) *Method of payment.* Facilities will be reimbursed under a cost-related vendor payment program. A per diem rate will be established based on information submitted according to rule 441—82.4(249A).

82.11(2) *Periods authorized for payment.*

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.11(3) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person. However, the resident or the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over ten days on a hospital stay. When the resident is not discharged from the facility, the payments will not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

This rule is intended to implement Iowa Code section 249A.12.

441—82.12(249A) Billing procedures. Claims for service for clients not enrolled with a managed care organization must be sent to the department after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through the department's electronic clearinghouse.

82.12(1) A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

82.12(2) Adjustments to claims may be made electronically as provided for by the department.

This rule is intended to implement Iowa Code section 249A.12.

441—82.13(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Audits.

82.14(1) *Audits of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the financial and statistical report are reasonable and proper according to the rules set forth in 441—82.4(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent financial and statistical report, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.14(2) *Auditing of proper billing and handling of patient funds.*

a. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals, and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.8(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation that would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph "*d.*," the requested refunds may be withheld from future payments to the facility. The withholding will not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding will continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

441—82.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.15(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.56(249A).

82.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds will be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

441—82.16(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month will receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 87
“Family Planning Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6 and 217.41B
State or federal law(s) implemented by the rulemaking: Iowa Code section 217.41B

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@idph.iowa.gov

Purpose and Summary

This proposed chapter outlines the details of eligibility criteria, funding, provider criteria, and covered services for the Family Planning Program.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
A person applying for, interested in, or participating in the State of Iowa Family Planning Program will benefit.
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 March 2024, there were approximately 2,800 members enrolled in the Family Planning Program. These rules provide for consistent and accurate eligibility determinations for individuals currently enrolled and any future applicants of the program.
 - Qualitative description of impact:
These rules play an important role in providing clarity, specificity, structure, and a legal basis for decisions made by the Department. This chapter also provides guidelines for provider participation, distribution of funds and claim submission.
3. Costs to the State:

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

The Department incurs personnel costs to implement the program.

- Anticipated effect on state revenues:

No additional costs are anticipated beyond those already appropriated.

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

The absence of these rules could lead to confusion, lack of information, and lack of clear legal authority.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

No alternative methods were seriously considered.

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

Much of the benefit can be achieved through Employee Manuals and forms prescribed by the Department. However, an additional framework is needed to provide clarity, consistency, and a legal basis for decisions made by the Department.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 87 and adopt the following **new** chapter in lieu thereof:

CHAPTER 87 FAMILY PLANNING PROGRAM

441—87.1(217) Definitions.

“*Applicant*” means a person who applies for assistance under the family planning program described in this chapter.

“*Authorized Title X agency*” means an agency or entity with an executed memorandum of understanding (MOU) with the Iowa department of health and human services (department) authorizing the agency to perform point-of-service eligibility determinations for the family planning program.

“*Citizen*” or “*citizenship*” includes both citizens of the United States and nationals of the United States as defined in 8 U.S.C. Section 1101(a)(22).

“*Family planning services*” means pregnancy prevention and related reproductive health services.

“*Federal poverty level*” means the levels published and updated periodically in the Federal Register by the United States Department of Health and Human Services (DHHS) under the authority of 42 U.S.C. Section 9902(2) and revised annually on April 1.

“*Member*” means a person who has been determined eligible and is a current or former recipient of family planning program services.

“*Noncitizen*” means the same as the term “alien” as defined at 8 U.S.C. Section 1101(a)(3).

“*Qualified noncitizen*” means the same as the term “qualified alien” as defined at 8 U.S.C. Section 1641(b) and (c) and refers to a person who is:

1. Lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Granted asylum in the United States under Section 208 of the INA;
3. A refugee admitted to the United States under Section 207 of the INA;
4. Paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. A person whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA;
6. Granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. An Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. A Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. A battered noncitizen as described in 8 U.S.C. Section 1641(c);
10. Certified as a victim of trafficking as described in Section 107(b)(1)(A) of PL 106-386;
11. An American Indian born in Canada to whom Section 289 of the INA applies or a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e);
12. Under the age of 21 and lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii); or
13. Lawfully residing in the United States in accordance with a Compact of Free Association with the government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of PL 116-260.

“*Qualifying quarters*” means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of a noncitizen while the noncitizen was under the age of 18 and all of the qualifying quarters worked by a spouse of the noncitizen during their marriage if the noncitizen remains married to the spouse or the spouse is deceased. No qualifying quarters of coverage that are creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to a noncitizen if the parent or spouse of the noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter is credited.

441—87.2(217) Eligibility. Eligibility for the family planning program will be determined according to the provisions of this rule.

87.2(1) Persons covered. Subject to funding as described in subrule 87.7(1) and to the requirements of subrules 87.2(2), 87.2(4), and 87.2(6), assistance for family planning services will be available to the following individuals who are not enrolled in medical assistance pursuant to 441—Chapter 74 or 441—Chapter 75:

- a.* Women who were enrolled in medical assistance when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends;

b. Women who are under the age of 55, who are capable of bearing children but are not pregnant, and who have household income that does not exceed 300 percent of the federal poverty level as determined pursuant to subrule 87.2(3);

c. Men who are under the age of 55, who are capable of fathering children, and who have household income that does not exceed 300 percent of the federal poverty level as determined pursuant to subrule 87.2(3).

87.2(2) *Furnishing of social security number.* As a condition of eligibility, except as provided by paragraph 87.2(2)“a,” an applicant or member must provide to the department or authorized Title X agency, as applicable, all social security numbers issued to each individual (including children) for whom family planning services are sought.

a. The requirement of furnishing a social security number does not apply to an individual who:

(1) Is not eligible to receive a social security number;

(2) Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR §422.104 as amended to March 15, 2022; or

(3) Refuses to obtain a social security number because of a well-established religious objection.

For this purpose, a well-established religious objection means that the individual:

1. Is a member of a recognized religious sect or division of a sect; and

2. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

b. If a required social security number has not been issued or is not known, the individual seeking coverage under the family planning program must cooperate with the department or authorized Title X agency, as applicable, in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

87.2(3) *Determination of household income.* The department will determine the countable household income of an individual applying under paragraph 87.2(1)“b” or “c” as follows:

a. *Household composition.*

(1) The household includes the applicant or member, any dependent children, as defined below, living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Definition of dependent children. A dependent child is one under the age of 18 years or aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19.

b. *Earned income.* All earned income that is received by a member of the household shall be counted except for earnings of a child who is a full-time student as defined in subparagraph 87.2(3)“a”(1). Earned income, including but not limited to the following, will be counted:

(1) Salary.

(2) Wages.

(3) Tips.

(4) Bonuses.

(5) Commissions.

(6) Income from Job Corps.

(7) Earnings from self-employment defined as gross income less the allowable costs of producing the income.

c. *Unearned income.* The following unearned income of all household members will be counted:

(1) Unemployment insurance benefits.

(2) Child support.

(3) Alimony.

(4) Social security and railroad retirement benefits.

- (5) Workers' compensation and disability payments.
- (6) Benefits paid by the U.S. Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

d. Deemed income. Income deeming for a sponsored alien will be determined pursuant to subrule 87.2(5).

e. Deductions. Deductions from income will be made for any payments made by household members for the following:

- (1) Court-ordered child support, alimony, or spousal support paid to nonhousehold members.
- (2) Twenty percent of nonexempt earnings.
- (3) Child care expenses or expenses related to care for an incapacitated adult. This deduction cannot exceed \$200 per month for each child under the age of two and \$175 per month for each adult or child aged two or older.

87.2(4) Citizenship or alienage requirements.

a. To be eligible for the family planning program, a person must be one of the following:

- (1) A citizen or national of the United States.
- (2) A qualified noncitizen continuously present (as described in Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility, under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) at 62 CFR §61415 dated November 11, 1997) in the United States since August 22, 1996.
- (3) A qualified noncitizen under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the INA.
- (5) A noncitizen who has been granted asylum under Section 208 of the INA.
- (6) A noncitizen whose deportation is withheld under Section 243(h) or 241(b)(3) of the INA.
- (7) A qualified noncitizen veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified noncitizen who is on active duty in the armed forces of the United States other than active duty for training.
- (9) A qualified noncitizen who is the spouse or unmarried dependent child of a qualified noncitizen described in subparagraph 87.2(4) "a"(7) or 87.2(4) "a"(8), including a surviving spouse who has not remarried.
- (10) A qualified noncitizen who has resided in the United States for a period of at least five years beginning on the date of the qualified noncitizen's entry into the United States with a status within the meaning of subparagraph 87.2(4) "a"(1), 87.2(4) "a"(4), or 87.2(4) "a"(9) under the definition of "qualified noncitizen" in rule 441—87.1(217).
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of PL 106-386.
- (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e).
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of PL 110-181 or to Section 602(b)(8) of PL 111-8.
- (16) An Afghan paroled into the United States treated as a refugee pursuant to Section 2502 of PL 117-43.
- (17) A qualified noncitizen lawfully residing in the United States in accordance with a Compact of Free Association with the government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of PL 116-260.
- (18) A conditional entrant pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980.

b. As a condition of eligibility, all applicants for or members of the family planning program shall attest to their citizenship or qualified noncitizen status by signing the application or review form.

c. Except as provided in paragraph 87.2(4)“h,” applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph 87.2(4)“b” will present satisfactory documentation of citizenship as described in paragraph 87.2(4)“d” or “e.” A reference to a form in paragraph 87.2(4)“d” or “e” includes any successor form. An applicant or member who attests to citizenship must also verify the applicant’s identity. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the “reasonable period” begins on the date a written request for documentation is issued to an applicant or member and continues for 90 days.

(2) Family planning services will be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality.

d. Any one of the following documents must be accepted as satisfactory documentation of citizenship and identity:

(1) A United States passport, including a U.S. passport card issued by the U.S. Department of State, without regard to any expiration date as long as such passport or card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of United States Citizenship.

(4) A valid U.S. state-issued driver’s license, but only if the state issuing the license does either of the following prior to issuance of the license:

1. Requires proof of United States citizenship; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian tribe as described at 42 CFR §435.407 as amended to March 15, 2022, including but not limited to a tribal enrollment card, a Certificate of Degree of Indian Blood, a tribal census document, or a document on tribal letterhead issued under the signature of the appropriate tribal official. Acceptable documentation:

1. Identifies the federally recognized Indian tribe that issued the document;

2. Identifies the individual by name; and

3. Confirms the individual’s membership, enrollment, or affiliation with the tribe.

(6) Another document that provides proof of United States citizenship and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship and identity may also be demonstrated by the combination of any identity document described in paragraph 87.2(4)“f” and any one of the following:

(1) A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the U.S. Virgin Islands, American Samoa, Swain’s Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986 (CNMI local time)). The birth record document may be issued by a state, commonwealth, territory, or local jurisdiction. If the document shows that the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following establishes U.S. citizenship for collectively naturalized individuals:

1. Puerto Rico: Evidence of birth in Puerto Rico and the applicant’s statement that the applicant was residing in the U.S., a U.S. possession, or Puerto Rico on or after January 13, 1941.

2. CNMI (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

- Evidence of birth in the CNMI; evidence of TTPI citizenship and residence in the CNMI, the U.S., or a U.S. territory or possession on or after November 3, 1986 (CNMI local time); and the applicant’s statement that the applicant did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time);

- Evidence of TTPI citizenship, continuous residence in the CNMI since before November 3, 1981 (CNMI local time); voter registration before January 1, 1975; and the applicant's statement that the applicant did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time);
- Evidence of continuous domicile in the CNMI since before January 1, 1974, and the applicant's statement that the applicant did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time).

Note: If a person entered the CNMI as a nonimmigrant and lived in the CNMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

- (2) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.
- (3) A Report of Birth Abroad of a U.S. citizen.
- (4) A certificate of birth in the U.S.
- (5) A U.S. Citizen I.D. card.
- (6) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).
- (7) A final adoption decree showing the child's name and U.S. place of birth or, if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.
- (8) Evidence of U.S. Civil Service employment before June 1, 1976.
- (9) A U.S. military record showing a U.S. place of birth.
- (10) Documentation that a child meets the requirements of Section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. Section 1431).
- (11) Medical records, including but not limited to hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.
- (12) A life, health, or other insurance record that indicates a U.S. place of birth.
- (13) An official religious record recorded in the U.S. showing that the birth occurred in the U.S.
- (14) School records, including preschool, Head Start, and day care, showing the child's name and U.S. place of birth.
- (15) Federal or state census records showing U.S. citizenship or a U.S. place of birth.

If the applicant does not have one of the documents listed in paragraph 87.2(4)“d” or subparagraphs 87.2(4)“e”(1) through 87.2(4)“e”(15), the applicant may submit an affidavit using a form prescribed by the department, signed under penalty of perjury by another individual who can reasonably attest to the applicant's citizenship. Such affidavit must contain the applicant's name, date of birth, and place of U.S. birth. The affidavit is not required to be notarized.

f. Any of the following documents must be accepted as satisfactory documentation of identity, provided the document has a photograph or other identifying information sufficient to establish identity, including but not limited to name, age, sex, race, height, weight, eye color, or address:

- (1) Identity documents listed at 8 CFR §274a.2(b)(1)(v)(B)(1) as amended to March 15, 2022, except a driver's license issued by a Canadian government authority.
- (2) A driver's license issued by a state or territory.
- (3) A school identification card.
- (4) A U.S. military card or draft record.
- (5) An identification card issued by the federal, state, or local government.
- (6) A military dependent's identification card.
- (7) A U.S. Coast Guard Merchant Mariner card.
- (8) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.
- (9) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include but are not limited to employer identification cards; high school, high school equivalency, and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(10) A finding of identity from a federal agency or another state agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

If the applicant does not have any document specified in subparagraphs 87.2(4)“f”(1) through 87.2(4)“f”(10), the applicant may submit an affidavit using a form prescribed by the department signed under penalty of perjury by another individual who can reasonably attest to the applicant’s identity. Such affidavit must contain the applicant’s name and other identifying information establishing identity, as described in paragraph 87.2(4)“f.” The affidavit is not required to be notarized.

g. The department or authorized Title X agency, as applicable, must accept a photocopy, facsimile, scanned, or other copy of a document listed in paragraph 87.2(4)“d,”“e,” or “f” to the same extent as an original document, unless information on the submitted copy is inconsistent with other information available or there is reason to question the validity of, or information in, the document. The department must provide assistance in a timely manner to persons who need assistance in securing satisfactory documentation of citizenship or identity.

h. A person for whom an attestation of United States citizenship has been made pursuant to paragraph 87.2(4)“b” is not required to present documentation of citizenship and identity for the family planning program if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d) of the Act).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is or was exempted while assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act on the basis of being a child in foster care as defined in Iowa Code section 232.2(20B). This exemption does not apply, and the person is subject to the citizenship and identity documentation requirements described in paragraph 87.2(4)“c,” when services under Part B of Title IV were terminated due to failure to meet citizenship requirements.

(5) The person is or was exempted while assisted by foster care as defined in Iowa Code section 232.2(20B) or adoption assistance funded under Part E of Title IV of the federal Social Security Act. This exemption does not apply, and the person is subject to the citizenship and identity documentation requirements described in paragraph 87.2(4)“c,” when services under Part E of Title IV were terminated due to failure to meet citizenship requirements.

(6) The person has previously presented satisfactory documentation of citizenship and identity, as specified by the United States Secretary of Health and Human Services.

(7) The person was deemed eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) on or after July 1, 2006, as the newborn of a Medicaid-eligible mother.

(8) The person was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children’s Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

i. Except as provided in paragraph 87.2(4)“h,” applicants or members for whom an attestation of qualified noncitizen status has been made pursuant to paragraph 87.2(4)“b” will present satisfactory documentation of qualified noncitizen status. Satisfactory documentation of qualified noncitizen status is documentation issued by the U.S. Citizenship and Immigration Services (USCIS) (formerly Immigration and Naturalization Service (INS)) of the Department of Homeland Security that identifies the person’s qualified noncitizen status.

87.2(5) Deeming of sponsor’s income.

a. When a qualified noncitizen admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of

the qualified noncitizen, the income of the sponsor will be deemed to determine eligibility for the sponsored qualified noncitizen. The amount deemed to the sponsored qualified noncitizen will be the total countable income of the sponsor determined pursuant to paragraphs 87.2(3) “b” through “d.”

b. An indigent qualified noncitizen is exempt from the deeming of a sponsor’s income for 12 months after indigence is determined. A qualified noncitizen will be considered indigent if:

- (1) The qualified noncitizen does not live with the sponsor; and
- (2) The qualified noncitizen’s gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored qualified noncitizen’s household size.

c. A battered qualified noncitizen as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor’s income for 12 months.

d. Deeming of the sponsor’s income does not apply when:

(1) The sponsored qualified noncitizen attains citizenship through naturalization pursuant to Chapter 2 of Title II of the INA.

(2) The sponsored qualified noncitizen has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 creditable qualifying quarters as defined in rule 441—87.1(217).

(3) The sponsored qualified noncitizen or the sponsor dies.

(4) The sponsored qualified noncitizen is a child under the age of 21 as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

87.2(6) *Residency requirements.* Residency in Iowa is a condition of eligibility for the family planning program.

a. Definition of resident. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A person is a resident of Iowa when living there on other than a temporary basis. Residence will not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed.

b. Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

87.2(7) *Investigation by quality control or the department of inspections, appeals, and licensing.* As a condition of eligibility, an applicant or member must cooperate with the department when the applicant’s or member’s case is selected by quality control or the department of inspections, appeals, and licensing for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income does not affect family planning program eligibility. (More information can be found in 481—Chapter 72.) Failure to cooperate will serve as a basis for denial of an application or cancellation of family planning program eligibility. Once a person’s eligibility is denied or canceled for failure to cooperate, the person may reapply but cannot be determined eligible until cooperation occurs.

87.2(8) *Funding contingency.* Initial and continuing eligibility for family planning services under this program is subject to the availability of funding appropriated for this purpose.

a. When appropriated funding is exhausted, ongoing eligibility will be terminated and new applications will be denied.

b. When appropriated funding becomes available, applications submitted thereafter will be considered on a first-come, first-served basis, based on the date of approval.

441—87.3(217) Enrollment.

87.3(1) Application. An individual who requests assistance for family planning services shall file an application on a form prescribed by the department. A woman eligible under paragraph 87.2(1) “a” is not required to file an application for assistance under this program. The department will automatically redetermine eligibility upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

87.3(2) Place of filing. An application may be filed at any department office or authorized Title X family planning agency.

87.3(3) Information or verification needed to determine eligibility. The department or authorized Title X agency, as applicable, will notify the applicant or member, authorized representative, or responsible person in writing of the information or verification required to establish eligibility. This notice must be provided to the applicant or member, authorized representative, or responsible person personally or by mail or fax.

a. The department or authorized Title X agency, as applicable, will allow the applicant or member, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

b. The department or authorized Title X agency, as applicable, may extend the deadline for a reasonable period of time when the applicant or member, authorized representative, or responsible person is making reasonable efforts but is unable to secure the required information or verification.

c. If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department or authorized Title X agency, as applicable, will complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or member, authorized representative, or responsible person will have until the next business day to provide the information.

87.3(4) Annual review. An individual who requests that assistance continue for family planning services shall complete a form prescribed by the department. The member must submit the completed review form before the end of the eligibility period to any location specified in subrule 87.3(2).

87.3(5) Time limit for decision. An application or review form will be processed by the department or authorized Title X agency with which the form was filed. A determination of eligibility will be made within 45 days of receipt of the application or review form.

87.3(6) Notice of decision. The individual will be notified in writing of the decision regarding eligibility for the family planning program.

441—87.4(217) Effective date of eligibility. Subject to the availability of funding appropriated for this purpose, assistance for family planning services under this program will be effective on the first day of the month of application or the first day of the month in which all eligibility requirements are met, whichever is later. Assistance will not be available under this program for any months prior to the month of application.

441—87.5(217) Period of eligibility. Eligibility for family planning services under this program will be limited to a period of 12 months from the effective date of eligibility, or the duration of appropriated funding, whichever is less. A new application or annual redetermination of eligibility is required for benefits to continue beyond 12 months.

441—87.6(217) Reporting changes.

87.6(1) Required changes to report. An individual applying for or receiving family planning services under this program shall report the following changes within ten days from the date the change is known:

- a.* Change in mailing address;
- b.* No longer a resident of Iowa;

- c. A woman becomes pregnant;
- d. No longer capable of bearing or fathering children;
- e. Becomes Medicaid or Iowa health and wellness plan eligible, except women meeting criteria in paragraph 87.2(1) “a”; or
- f. Turns 55 years of age.

87.6(2) *Disregard of changes.* An individual found to be eligible upon application or annual redetermination of eligibility will remain eligible for 12 months or the duration of appropriated funding, whichever is less, regardless of any change in income or household size.

441—87.7(217) Funding of family planning services program.

87.7(1) *Distribution of funds.* Distribution of family planning services program funds shall be made to eligible, approved, and participating family planning providers subject to rule 441—87.11(217). Eligible family planning providers shall not include any provider that performs abortions or that maintains or operates a facility where abortions are performed and must attest to this fact. Effective July 1, 2018, eligible family planning providers shall be interpreted to include a distinct location of a nonprofit health care delivery system, if the distinct location provides family planning services but does not perform abortions or maintain or operate as a facility where abortions are performed. For the purposes of this subrule, “nonprofit health care delivery system” means an Iowa nonprofit corporation that controls, directly or indirectly, a regional health care network consisting of hospital facilities and various ambulatory and clinic locations that provide a range of primary, secondary, and tertiary inpatient, outpatient, and physician services. For the purposes of this subrule, “abortion” does not include any of the following:

- a. The treatment of a woman for a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death.
- b. The treatment of a woman for a spontaneous abortion, commonly known as a miscarriage, when not all of the products of human conception are expelled.

87.7(2) *Recovery.* The department will recover from a member all funds incorrectly expended to or on behalf of the member for family planning program services.

441—87.8(217) Availability of services. Family planning services are payable for an individual enrolled in this program only when care is received at or authorized by a participating family planning provider.

87.8(1) Sterilization is a covered service subject to the limitations in 441—Chapter 78.

87.8(2) Covered services cannot include abortion services.

441—87.9(217) Payment of covered services. Payment for family planning services covered under this chapter, including services authorized but not provided by a participating family planning provider, can be made only to participating family planning providers on a fee schedule determined by the department. Family planning services program funds distributed in accordance with this rule will not be used for direct or indirect costs, including but not limited to administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utility costs, related to providing abortions as specified in subrule 87.7(1).

87.9(1) *Fee schedule.* The fee schedule will include the amount of payment for each service and any limits on the service (e.g., a routine Pap smear is payable once annually).

87.9(2) *Third-party payments.* This program is the payer of last resort for services covered in this chapter. Any third-party payment received by the family planning agency or other provider of services plus any payments under this program cannot exceed the fee schedule allowance.

87.9(3) *Supplementation.* Payment made under this program is to be considered payment in full.

441—87.10(217) Submission of claims.

87.10(1) Family planning providers that participate in the program can submit claims to Iowa Medicaid for services rendered no later than 45 days from the last day of the month in which services were provided.

87.10(2) Following a successful review of the claim, the Iowa Medicaid enterprise will make payments to the family planning provider subject to the availability of funding and the allocation of available funds under subrule 87.7(1).

441—87.11(217) Providers eligible to participate.

87.11(1) Providers must be enrolled with the Iowa Medicaid program, subject to 441—Chapter 79, and otherwise qualified to provide family planning services under Medicaid, subject to the limitations related to abortions, as specified above under subrule 87.7(1). Effective July 1, 2018, as a condition of eligibility as a provider under the family planning services program, each distinct location of a nonprofit health care delivery system will enroll in the program as a separate provider, be assigned a distinct provider identification number, and complete an attestation that abortions are not performed at the distinct location. For the purposes of this subrule, “nonprofit health care delivery system” has the same meaning as provided under subrule 87.7(1).

87.11(2) Process for enrollment. Providers wishing to enroll under the state family planning program must complete the following steps:

- a.* Must complete enrollment with Iowa Medicaid.
- b.* Must complete a form prescribed by the department regarding nonprovision of abortions, pursuant to requirements referenced above under subrule 87.7(1).
- c.* Forms must be sent to the department at P.O. Box 36450, Des Moines, Iowa 50315.

These rules are intended to implement Iowa Code section 217.41B.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 109
“Child Care Centers”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 237A

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 237A and 45 CFR §98

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter assigns the minimum health, safety, and training requirements for licensed child care centers. This chapter aligns federal and state regulation with practical application of health and safety. Department licensing and regulatory staff utilize this chapter to inspect child care facilities and hold those facilities accountable to minimum standards. Standards are aligned to checklist and inspection reports.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are minimal costs to centers and center staff.
 - Classes of persons that will benefit from the proposed rulemaking:
Children and parents enrolled in child care centers will benefit. The child care centers will benefit as well.
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:
The rules were made by incorporating input from child care directors themselves to ensure the rules were not burdensome to meet, financially or otherwise. The rules were made to allow for more flexibility with the child care centers, while ensuring the safety of the children.

- Qualitative description of impact:

Child care center rules play a vital role in protecting children from harm and promoting their healthy development. Children spend a substantial amount of time outside of their home and in child care centers. It is critical this significant time is spent in a safe environment that promotes the children's well-being.

3. Costs to the State:

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

There are no additional costs beyond those already appropriated.

- Anticipated effect on state revenues:

There is no impact.

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

The absence of these rules could lead to unsafe environments for children and could create both immediate threats and long-term consequences.

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

None have been identified.

6. Alternative methods considered by the agency:

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

None have been seriously considered.

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

The Department supports child care center regulations in accordance with the Iowa Code, federal regulations and as required to protect the health and safety of children and staff.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 109 and adopt the following **new** chapter in lieu thereof:

CHAPTER 109 CHILD CARE CENTERS

441—109.1(237A) Definitions.

“*Adult*” means a person 18 years of age or older.

“Child” means the same as defined in Iowa Code section 237A.1.

“Child care” means the same as defined in Iowa Code section 237A.1.

“Child care center” or *“center”* means the same as defined in Iowa Code section 237A.1. For the purposes of this chapter, the word “center” applies to a child care center or preschool unless otherwise specified.

“Child care facility” or *“facility”* means the same as defined in Iowa Code section 237A.1.

“Coaching” means a relationship-based process led by an expert to build capacity for specific professional dispositions, skills and behaviors and is focused on performance-based outcomes.

“Education” means formal coursework offered through a state-approved accredited secondary school, college or university.

“Facility” means a building or physical plant established for the purpose of providing child day care.

“Get-well center” means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

“Involvement with child care” means the same as defined in Iowa Code section 237A.1.

“Parent” means parent or legal guardian.

“Person subject to an evaluation” means the same as defined in Iowa Code section 237A.5.

“Preschool” means the same as defined in Iowa Code section 237A.1.

“Professional development” means a continuum of learning activities designed to prepare and support individuals for work with children and families, including coaching, education, and training.

“Regulatory fee” means the amount payable to the department for licensure of a child care center based on the capacity of the center.

“Requesting entity” means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can have involvement with child care. The requesting entity must be a child care facility as defined in Iowa Code section 237A.1.

“Serious injury” means the same as defined in Iowa Code section 702.18.

“Training” means a learning experience that addresses a specific topic of professional relevance that builds or enhances knowledge.

“Transgression” means the same as defined in Iowa Code section 237A.5.

441—109.2(237A) Licensure procedures.

109.2(1) Application for license.

a. Any adult or agency has the right to apply for a license. The application for a license must be made to the department on a department-provided application for a license to operate a child care center.

b. Requested reports, including the fire marshal’s report and other information relevant to the licensing determination, will be furnished to the department upon application and renewal.

c. A center must submit all required fingerprints to the department of public safety before the issuance or renewal of the center’s license.

d. When a center makes a sufficient application for an initial license, the center may operate for a period of up to 120 calendar days from the date of issuance of the form granting permission to open without a license, pending a final licensing decision. A center has made a sufficient application when it has had an on-site visit and has submitted the following to the department:

(1) An application for a license.

(2) An approved fire marshal’s report.

(3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.

(4) Information sufficient to determine that the center director meets minimum personnel qualifications.

e. Applicants must submit the regulatory fee as specified in subrule 109.2(5) to the department.

f. Applicants must be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued a form granting permission to open without a license, the applicant must be notified of approval or denial within 120 calendar days of the date of issuance of the form.

(2) No full or provisional license will be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(5).

g. The department will not act on a licensing application for 12 months after an applicant's child care center license has been denied or revoked.

h. When the department has denied or revoked a license, the applicant or person is prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

109.2(2) License.

a. An applicant showing compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in subrule 109.2(5) to the department by the date due, shall be issued a license for 24 months. In determining whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department will make the final decision.

b. A new license must be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

c. A new license must be applied for when another adult or agency assumes ownership or legal responsibility for the center.

d. A provisional license may be issued or reduced pursuant to Iowa Code section 237A.2.

109.2(3) Denial. Initial applications or renewals will be denied when:

a. The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

b. The center is operating in a manner that the department determines impairs the safety, health, or well-being of children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(5) is not received by the department within 60 calendar days from the due date on the invoice.

109.2(4) Revocation and suspension. A license will be revoked or suspended if corrective action has not been taken when:

a. The center does not comply with center licensing laws or these rules.

b. The center is operating in a manner that the department determines impairs the safety, health, or well-being of the children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal, fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(5) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

109.2(5) *Regulatory fees.* A fee based upon center capacity is due to the department at the time of issuance of the license in accordance with this subrule.

a. Fee structure. The amount of the fee is based on the capacity of the center as indicated below:

<u>Center Capacity</u>	<u>Fee Amount</u>
0 to 20 children	\$50
21 to 50 children	\$75
51 to 100 children	\$100
101 to 150 children	\$125
151 or more children	\$150

b. Determination of capacity. The licensing consultant must determine center capacity by dividing the amount of usable space by the amount of space required per child as specified in subrule 109.11(1). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) are maintained.

c. Notification. Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee must sign and provide the child care center licensing fee invoice to the center.

d. Payment. The center must return the child care center licensing fee invoice to the department with the licensing fee payment within 60 calendar days from the date on the invoice. Regulatory fees are nonrefundable and nontransferable.

109.2(6) *Adverse actions.*

a. Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision will be given to applicants and licensees in accordance with 441—Chapter 7 and 441—subrule 16.2(3).

b. A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license must be conspicuously posted at the main entrance to the facility. The letter will remain posted until resolution of the action to deny, suspend, or revoke the license. If the action to deny, suspend, or revoke is upheld, the center must return the license to the department.

c. If the center's license is denied, suspended, or revoked, the department will notify the parent, guardian, or legal custodian of each child for whom the facility provides child care.

d. The center must cooperate with the department in providing the names and addresses of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

441—109.3(237A) *Inspection and evaluation.* The department will conduct an unannounced on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and will determine compliance with licensing standards imposed by licensing laws and these rules when a valid complaint is received.

109.3(1) At least one unannounced on-site visit will be conducted each calendar year.

109.3(2) After each visit and valid complaint, the department will document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

109.3(3) The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and valid complaints will be available to the public. However, the identity of the complainant will be withheld unless expressly waived by the complainant.

441—109.4(237A) *Administration.*

109.4(1) *Required written policies.* The child care center owner, board or director shall:

a. Develop and implement policies for enrollment and discharge of children, field trips and noncenter activities, discipline/behavior, nutrition, health and safety policies and, if transporting children, transportation policy.

b. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.

c. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of this chapter.

d. Make available for review a copy of the center policies and programs to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.

e. When serving children under the age of three, develop and implement a policy for responding to incidents of biting.

f. Develop and implement a policy to ensure that people do not have unauthorized access to children at the center.

g. Develop and implement a policy for protection of each child's confidentiality.

h. Develop and implement procedures for medical and dental emergencies, and ensure through orientation and training that all staff are knowledgeable of and able to implement the procedures.

109.4(2) Required postings. The following postings must be conspicuously posted in an area frequented by parents or the public:

a. Certificate of license at the main entrance of the center.

b. Notice of exposure of children to a communicable disease. The notice of exposure of children to a communicable disease will include the symptoms and the period of communicability.

c. Notice of decision to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status, if applicable.

d. Mandatory reporter requirements.

e. Notice of availability of the handbook "Child Care Centers and Preschools Licensing Standards and Procedures" (August 1, 2024).

f. Name and contact information of the department's child care licensing consultant.

g. Program activities and menu.

109.4(3) Mandatory reporters. Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

441—109.5(237A) Parental participation. Parents must be afforded unlimited access to their children and to the provider caring for their children during the center's hours of operation or whenever their children are in the care of a provider unless parental contact is prohibited by court order. The provider will inform all parents of this policy in writing at the time the child is admitted to the center.

441—109.6(237A) Personnel. The director of the center must develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

109.6(1) Center director requirements. Centers that have multiple sites must have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and program administration. The director must ensure services are provided for the children within the framework of the licensing requirements. The center director must have overall responsibility for carrying out the program and ensuring the safety and protection of the children. The following minimum qualifications must be submitted to the child care consultant for final approval prior to the start of employment. The center director:

a. Is at least 21 years of age.

b. Has obtained a high school diploma or passed a general education development test.

c. Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, recordkeeping, or budgeting, or has one year of administrative-related experience.

d. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR); infant, child, and adult first aid; and Iowa's training for the mandatory reporting of child abuse.

e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT- RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	25	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	60	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	45	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's or higher degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	25	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category must have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity must be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(2) On-site supervisor. The on-site supervisor is required to be present when the program has multiple sites or when a director is not routinely present for six hours daily. The center director must identify a person in charge during the on-site supervisor's absence. The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of six hours of the center's hours of operation. The following minimum qualifications will be submitted to the child care consultant for final approval prior to the start of employment. The on-site supervisor:

- a. Is at least 18 years of age.
- b. Has obtained a high school diploma or passed a general education development test.
- c. Has certification in infant, child, and adult CPR; infant, child, and adult first aid; and Iowa's mandatory reporting of child abuse.

d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the chart and calculation described in subrule 109.6(1). A minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points must be obtained from the experience category.

109.6(3) Volunteers. A volunteer must be at least 16 years of age. All volunteers shall:

- a. Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

b. Sign a statement indicating the volunteer has been informed of the volunteer's responsibilities as a mandatory reporter.

c. Undergo the record check process when any of the following criteria are met:

(1) The volunteer is included in meeting the required child-to-staff ratio;

(2) The volunteer has direct responsibility for a child or children; or

(3) The volunteer has access to a child or children with no other staff present.

d. Have on file at the facility a record containing the statements required in paragraphs 109.6(3) "a" and "b" and documentation of any record check process. The record must be maintained as required in paragraph 109.9(1) "a."

109.6(4) Record checks.

a. Criminal and child abuse record checks. Criminal and child abuse record checks shall be conducted for:

(1) Each owner, director, staff member, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

(2) Anyone living in the child care facility who is 14 years of age or older.

b. Authorization. A requesting entity shall request a record check evaluation prior to the employment of a person subject to record checks. The person subject to record checks shall complete the department's criminal history record check form and any other forms required by the department of public safety to authorize the release of records.

c. Iowa records checks. Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, must be completed before the person's involvement with child care at the center. Iowa records checks must be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center will send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph 109.6(4) "c"(1), the department must conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. The department may access SING to conduct the record check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

d. National criminal history checks. National criminal history checks based on fingerprints are required for all persons subject to record checks. The national criminal history check must be repeated for each person every four years and when the department or center becomes aware of any new transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center will provide fingerprints to the department of public safety prior to a person's involvement with child care at the center. The center will submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver must be submitted on a form prescribed by the department to the address listed on the form.

(5) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide that information in writing upon a center's request, using a form prescribed by the department. If the person being considered for employment has not had involvement with child care in the past six months, a new national criminal history check must be completed.

(6) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, must send a copy of the results to the department for evaluation. The department will determine whether or not the person may be involved with child care.

e. Mandatory and mandatory time-limited prohibition. A person with any convictions or founded abuse reports as defined in Iowa Code section 237A.5(2) "i" is prohibited from involvement with child care.

f. Evaluation required. For all other transgressions, and as requested under paragraph 109.6(4) "e," the department will notify the requesting entity that an evaluation shall be conducted to determine whether prohibition of the person's involvement with child care is warranted.

(1) The person with the transgression must complete the record check evaluation form. The requesting entity must provide the form and any other documents to the department within ten calendar days of the date on the form. The department will use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and the requesting entity to return this form by the specified date will result in denial or revocation of the license or denial of employment. The department will not process evaluations that are not signed by the person subject to an evaluation.

(2) The department may use information from the department's case records in performing the evaluation.

(3) The requesting entity may provide, or the department may request from the person subject to an evaluation or from the requesting entity, information to assist in performance of the evaluation.

(4) Any person or agency that might have pertinent information regarding criminal or abuse history and rehabilitation of the prospective employee may be contacted.

(5) In an evaluation, the department will consider all of the factors established in Iowa Code section 237A.5(2) "h."

(6) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the provisions established in Iowa Code section 237A.5(2) "g."

g. Evaluation decision. Within 30 days of receipt of a completed record check evaluation, the department will make a decision on the person's involvement with child care. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department will mail to the requesting entity and the person on whom the evaluation was completed the record check decision that explains the decision reached regarding the evaluation of the transgression.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person will be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department will send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter will inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

h. Notice to parents. The department will provide notification of founded child abuse committed by an owner, director, or staff member of the child care center pursuant to Iowa Code section 237A.5(2) "k." The center must cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

109.6(5) Use of controlled substances and medications. All owners, personnel, and volunteers must be free of the use of illegal drugs and not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

441—109.7(237A) Professional growth and development. Professional development will supplement the educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served.

The center director, on-site supervisor, and staff counted as part of the staff ratio must meet the following minimum staff training requirements:

109.7(1) Required training within the first three months of employment. During their first three months of employment, all staff must receive the following training:

- a.* Iowa's training for mandatory reporting of child abuse.
- b.* At least one hour of training regarding universal precautions.
- c.* Certification in infant, child, and adult CPR. A valid certificate indicating the date of training and expiration date will be maintained.
- d.* Certification in infant, child, and adult first aid. A valid certificate indicating the date of training and expiration date must be maintained.
- e.* Essentials child care pre-service or equivalent minimum health and safety training approved by the department in the following areas:
 - (1) Prevention and control of infectious disease, including immunizations.
 - (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
 - (3) Administration of medication, consistent with standards for parental consent.
 - (4) Prevention of and response to emergencies due to food and allergic reactions.
 - (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
 - (6) Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment.
 - (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
 - (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
 - (9) Precautions in transporting children.
 - (10) Child development.

Essentials child care pre-service or equivalent minimum health and safety training may be required if content has significant changes that warrant that the training be renewed.

Child care staff employed in programs that only serve children over the age of three are exempt from taking health and safety trainings under subparagraphs 109.7(1) "e"(2) and 109.7(1) "e"(6).

109.7(2) *Center directors and all staff.*

a. During their first year of employment, all center directors and all staff will receive the following training:

(1) Ten contact hours of training from approved subject areas from the Council for Professional Recognition or approved content areas from the National Afterschool Association.

(2) Training received for CPR, first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours.

(3) A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

b. Following their first year of employment, all center directors and all staff must:

(1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.

(2) Staff must receive six contact hours of professional development annually from one or more of the subject areas under subparagraph 109.7(2) "a"(1).

(3) Center directors and on-site supervisors must receive eight contact hours of training annually from one or more approved subject areas under subparagraph 109.7(2) "a"(1).

109.7(3) *Staff employed in centers that operate summer-only programs.* During their first three months of employment, all staff shall receive the following training:

a. Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions.

c. Certification in infant, child, and adult CPR. A valid certificate indicating the date of training and expiration date shall be maintained.

d. Certification in infant, child, and adult first aid. A valid certificate indicating the date of training and expiration date shall be maintained.

e. Essentials child care pre-service or equivalent minimum health and safety training approved by the department in the following areas:

(1) Prevention and control of infectious disease, including immunizations.

(2) Prevention of sudden infant death syndrome and use of safe sleep practices.

(3) Administration of medication, consistent with standards for parental consent.

(4) Prevention of and response to emergencies due to food and allergic reactions.

(5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.

(6) Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment.

(7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.

(8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.

(9) Precautions in transporting children.

(10) Child development.

Child care staff employed in programs that only serve children over the age of three are exempt from taking health and safety trainings under subparagraphs 109.7(3) "e"(2) and 109.7(3) "e"(6).

109.7(4) *Substitution.* A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC) (August 1, 2024), or Early Childhood-Positive Behavior Interventions and Supports (EC-PBIS) training series (August 1, 2024) may use those hours to fulfill a maximum of two years' professional development requirements, not including preservice, first-aid, CPR and mandatory reporter training.

109.7(5) *Approved professional development.*

a. Professional development contact hours can be coaching, education, or training provided by a department-approved entity.

b. Coaching contact hours may only be used to meet up to half of an individual's annual professional development requirement.

c. The department may randomly monitor any state-approved professional development for quality control purposes.

d. Professional development conducted with staff during the hours of operation of the facility, during staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff must not be actively engaged in care and supervision and simultaneously participate in training.

e. A professional development organization not approved by the department may submit for review to the department a request for child care training approval. All approvals unless otherwise specified shall be valid for five years. The department will issue its decision within 30 business days of receipt of a complete request.

f. Department-approved entities must provide participants a professional development certificate for approved professional development contact hours.

109.7(6) Professional development for supervisors and designees. The director, on-site supervisor, and any person designated as a lead in the absence of supervisory staff must have completed all preservice/orientation training outlined in subrule 109.7(1).

441—109.8(237A) Staff ratio requirements.

109.8(1) Staff requirements. Persons counted as part of the staff ratio must meet the following requirements.

- a. Staff persons must be at least 16 years of age.
- b. Those staff persons who are under the age of 18 shall meet the following requirements:
 - (1) May not be the sole provider on the premises of a child care facility.
 - (2) Shall not provide transportation to children in care.
 - (3) If staff persons under the age of 18 are providing child care services without an adult, they shall only provide care to school-aged children.
 - (4) May be utilized for brief periods of absence as identified in paragraph 109.8(2)“g” and scheduled nap periods of children over two years of age as identified in paragraph 109.8(2)“h.”

109.8(2) Staff ratio. The staff-to-child ratio shall be as follows:

<u>Age of children</u>	<u>Minimum ratio of staff to children</u>
Two weeks to two years	One to every 4 children
Two years	One to every 7 children
Three years	One to every 10 children
Four years	One to every 12 children
Five years to ten years	One to every 15 children
Ten years and over	One to every 20 children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group.

b. Combinations of age groupings for children three, four, and five years of age may be allowed with a ratio of one staff member to every 12 children.

c. Children between 18 months and three years of age may be combined, if appropriate to the developmental needs of the child. If a child under two years of age is in a combined age group, the staff ratio of one to seven will be maintained. Otherwise, staff ratio may be determined by the age of the majority of the children in the group.

d. Combinations of age groupings that do not meet paragraphs 109.8(2)“a” through “c” may be approved by a child care licensing consultant when a program can show developmentally appropriate curriculum for all age groups and can provide sufficient supervision.

e. Combinations of age groupings for children five years of age and older must have a ratio consistent with the age of majority.

f. Upon the recommendation of a child's physician or the area education agency serving the child, a child who is two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

g. Every child-occupied program room must have supervision present in the room. Brief absences of a staff member may be allowed for no more than five minutes when another staff person is present.

h. During nap time, at least one staff member must be present in every room where children are resting. Staff ratio requirements may be reduced to one staff member per room where children are resting and staff ratio coverage can be maintained in the center. The staff ratio must always be maintained for children under two years of age.

i. When more than eight children are present on the licensed premises, at least two staff members shall be present.

j. For a period of two hours or less at the beginning and end of the center's hours of operation, one staff member may care for eight or fewer children, provided no more than four of the children are under two years of age and there are no more than eight children in the center.

k. When more than eight children are being transported in one vehicle, at least two staff members must be present, one of which is over 18 years of age.

(1) Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school.

(2) When a center contracts with another entity to provide transportation other than for the purpose of transporting children to or from school, at least one adult staff in addition to the driver must be present if at least eight children provided care by the center are transported.

l. Any child care center-sponsored program activity involving six or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children. At least one staff present on field trips must be over 18 years of age.

m. For centers serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early or canceled due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

109.8(3) *Group size.* Group size is determined in collaboration with the state fire marshal and will be assigned based on the review of health and safety requirements. Maximum capacity allowed shall be included on the certificate of license. Group sizes by age group must be included in annual inspection reports.

441—109.9(237A) Records.

109.9(1) *Personnel records.* The center will maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file must contain, at a minimum, the following:

a. Copies of all record checks kept in accordance with state and federal law regarding confidentiality of record checks. These records shall include:

(1) A copy of a department criminal history record check form or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of a request for child abuse information form, when applicable.

(3) Copies of the results of Iowa record checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a record check, regardless of findings.

b. A physical examination report. As required in Iowa Code section 237A.5(1), personnel shall have good health as evidenced by a preemployment physical examination. Acceptable physical examinations shall be documented on a form prescribed by the department. The examination shall be performed within six months prior to beginning employment and shall be repeated at least every three years. A physical examination may be requested if the employer has reason to believe an employee would not be able to perform a job successfully or safely due to a medical condition.

c. Documentation showing the minimum staff training requirements as outlined in rule 441—109.7(237A) are met, including current certifications in first aid and CPR and Iowa's training for the mandatory reporting of child abuse.

d. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

109.9(2) *Child's file.* Centers must maintain current and sufficient information in a file for each child that includes:

a. Child enrollment information, including name, age, date of birth, and address.

b. Parent/guardian contact information.

c. Emergency contacts and persons who can pick up the child as authorized by the parent.

d. Contact information and authorization of emergency medical and dental services.

e. Health and medical needs of a child, including any allergies or special health needs, a written emergency plan and prescribed treatment.

f. Incident reports of injuries, accidents, or other incidents, as applicable.

g. Parent authorization for a child to attend center-sponsored field trips and noncenter activities.

h. Signed and dated Religious Certificate of Immunization Exemption, provided by the department, must be on file for each child enrolled as required in 641—Chapter 7.

i. For each child not yet enrolled in kindergarten, the child care center must require a physical examination submitted at enrollment but no later than within four weeks of admission. The physical should include a health history and status of present health, including allergies, medications, acute or chronic conditions, and care plan when needed. The physical should be completed and signed by the child's primary health care provider (MD, DO, chiropractor, PA, or ARNP). The date of the physical examination shall be no more than 12 months prior to the first day of admission and annually thereafter until kindergarten entry.

j. For school-aged children, the child care center must have a statement of health signed by the parent indicating the child's health status, allergies, medications, acute or chronic conditions and care plan when needed.

k. For a child who has a special health need, there must be a written care plan completed and signed by the child's primary health care provider (MD, DO, chiropractor, PA, or ARNP) or parent or guardian. The care plan should include the care needed, when the care is to be given, and any possible complications or side effects, including required interventions. Documentation of special needs provided should be in a manner similar to documentation for medication administration.

109.9(3) *Daily activities.* For each child under two years of age, the center must make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

- a. The time periods in which the child has slept.
- b. The amount of food consumed and the times at which the child has eaten.
- c. The time of and any irregularities in the child's elimination patterns.
- d. The general disposition of the child.
- e. A general summary of the activities in which the child participated.

441—109.10(237A) Health and safety policies. The child care center will establish definite health policies, including the criteria for excluding a sick child from a center. The child care center may be provided guidance from the child care center's child care nurse consultant or the department regarding exclusion of an exposed child or staff during a communicable disease outbreak.

109.10(1) Medications. The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription medications, nonprescription medications, and nonmedicated topical products, including the following:

- a. Staff must be over 18 to administer medication.
- b. All medications must be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so the medications are inaccessible to children and the public. Nonprescription medications must be labeled with the child's name.
- c. For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration, including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.
- d. In the case of medications that are administered on an ongoing, long-term basis, authorization must be obtained for a period not to exceed the duration of the prescription.
- e. A child care staff member shall not provide medications to a child if the staff member has not completed preservice/orientation training that includes medication administration.

109.10(2) Daily contact. Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior that may adversely affect the child or the group.

109.10(3) Infectious disease control. Centers must establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily fluids that include blood, bodily excrement or discharge. Soiled diapers shall be stored in containers separate from other waste. Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

109.10(4) Quiet area for ill or injured. The center will provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person will be notified of the child's status in the event of a serious illness or emergency.

109.10(5) Staff hand washing. The center must ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease.

109.10(6) Children's hand washing. The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing, one for rinsing, and one for drying may be used in place of running water.

109.10(7) First-aid kit. The center must ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit must be sufficient to address first aid related to minor injury or trauma and stored in an area inaccessible to children.

109.10(8) Recording incidents.

- a. Incidents involving a child, including minor injuries, minor changes in health status, or other minor behavioral concerns, shall be reported to the parents, guardians, and legal custodians on the day of the incident.
- b. Incidents resulting in a serious injury, as defined in Iowa Code section 702.18, to a child in the child care facility or in the care of child care facility staff or incidents resulting in a significant change in the health status of a child must be verbally reported to the parents, guardians, and legal custodians immediately.

(1) Serious injuries must be reported to the department within 24 hours of the incident.

(2) Serious injuries must be documented and information maintained in the child's file as required by subrule 109.9(2).

c. The parents, guardians, and legal custodians of any child included in incidents involving inappropriate, sexually acting-out behavior must be notified immediately after the incident. A written report fully documenting every incident will be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident, and a copy will be retained in the child's file.

109.10(9) *Smoking.* Smoking and the use of tobacco products must be prohibited and nonsmoking signs must be posted pursuant to Iowa Code chapter 142D.

109.10(10) *Transportation.* Children must be transported pursuant to Iowa Code section 321.446.

109.10(11) *Field trips.* Emergency telephone numbers and emergency health plans, as applicable, for each child must be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

109.10(12) *Pets.* Animals kept on site must be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets; reptiles, including turtles; or birds of the parrot family can be kept on site. Pets are not allowed in the kitchen or food preparation areas.

109.10(13) *Emergency plans.*

a. The center shall have written emergency plans and diagrams for responding to fire, tornado, and flood (if area is susceptible to flood) and plans for responding to intoxicated parents and lost or abducted children. Emergency plans must include written procedures, including plans for the following:

- (1) Evacuation to safely leave the facility.
- (2) Relocation to a common, safe location after evacuation.
- (3) Shelter-in-place to take immediate shelter when the current location is unsafe to leave due to the emergency issue.
- (4) Lockdown to protect children and providers from an external situation.
- (5) Communication and reunification with parents or other adults responsible for the children that includes emergency telephone numbers.
- (6) Continuity of operations.
- (7) To address the needs of individual children, including those with functional or access needs.

b. Emergency instructions; telephone numbers; and diagrams for fire, tornado, and flood (if area is susceptible to floods) must be visibly posted by all program and outdoor exits. Emergency plan procedures must be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills must be maintained for the current and previous year.

c. The center must develop procedures for annual staff and volunteer training on these emergency plans and include information on responding to fire, tornadoes, intruders, intoxicated parents, and lost or abducted children in the orientation provided to new employees and volunteers.

d. The center must conduct a daily check to ensure that all exits are unobstructed.

109.10(14) *Supervision and access.*

a. The center director and on-site supervisor must ensure that each staff member or volunteer knows the number and names of children assigned to that staff member or volunteer for care. Assigned staff and volunteers must provide careful supervision.

b. Any person in the center who is not an owner, staff member, or volunteer who has a record check and department approval to be involved with child care must not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. A parent who is a registered sex offender under Iowa Code chapter 692A cannot be present upon the property of a child care center except for the time reasonably necessary to transport the offender's own minor child or ward to and from the center. Under limited circumstances, a center director may give written permission to be on the property. Before giving written permission, the center director will consult with the center licensing consultant. The written permission must be

signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

441—109.11(237A) Physical facilities.

109.11(1) *Room size.* The program room size must be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there must be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children cannot be used as regular program space or counted as useable floor space.

109.11(2) *Play equipment, materials and furniture.*

a. The center will provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission (CPSC) (August 1, 2024) or the American Society for Testing and Materials (ASTM) (August 1, 2024) for juvenile products. Play equipment, materials, and furniture must meet the developmental, activity, and special needs of the children.

b. Rooms must be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding will be provided for all children who nap. The center will develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing must be maintained. The center shall provide sufficient toilet articles for each child for hand washing.

109.11(3) *Indoor facility requirements.*

a. The center shall ensure that:

- (1) The facility and premises are sanitary, safe and hazard-free.
- (2) The facility has sufficient:
 1. Lighting.
 2. Ventilation.
 3. Heating and cooling.
- (3) Equipment placed in a program area is maintained so as not to result in injury to children.

109.11(4) *Outdoor facility requirements.*

a. Centers must have a safe outdoor program area adjacent to the center, with sufficient square footage to accommodate at least 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area must:

- (1) Be free from litter and unsafe materials and free from contamination by the drainage or ponding of sewage or storm water.
- (2) Include safe play equipment and an area of shade.
- (3) Include fencing to protect from bodies of water and vehicular traffic.

b. The director or designated person must complete and keep a record of at least monthly inspections of the outdoor play area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and must complete and document an inspection prior to resuming use of the area.

c. Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

d. Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

109.11(5) *Bathroom facilities.* At least one functioning toilet and one sink per 15 children two years of age and older must be provided in a room with natural or artificial ventilation. New construction after November 1, 1995, must provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink must be provided in program rooms for infants and

toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

109.11(6) Telephone. A working nonpay telephone must be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison control center posted in a conspicuous area. The street address and telephone number of the center must be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained.

109.11(7) Kitchen appliances. Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area must be sectioned off and shall not be counted as useable floor space for room size.

109.11(8) Environmental hazards.

a. Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1978 shall conduct a visual assessment for lead hazards that exist in the form of peeling, cracking or chipping paint or painted surfaces in need of repair. If these lead hazards are found, it shall be assumed that lead-based paint is present on the surfaces, and the surfaces shall be repaired by an Iowa certified lead-safe renovator before a full license will be issued.

b. Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing following the National Consensus Standards as outlined in 641—Chapter 43.

c. To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034 (August 7, 2024).

441—109.12(237A) Activity program requirements.

109.12(1) Activities. The center shall have a written curriculum that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

a. A curriculum or program of activities that supports development of self-esteem, self-regulation, positive social interactions, communication skills, curiosity, problem-solving, creative expression, and gross motor and fine motor development.

b. A balance of active and quiet activities, individual and group activities, indoor and outdoor activities, and staff-initiated and child-initiated activities.

c. Experiences in harmony with the ethnic and cultural backgrounds of the children.

d. A supervised nap or quiet time for all children under six years of age not enrolled in school who are present at the center for five or more hours.

109.12(2) Discipline. The center shall have a written policy that shall be provided to staff at the start of employment and to parents at the time of admission. The center shall not use as a form of discipline:

a. Corporal punishment, including spanking, shaking, and slapping.

b. Punishment that is humiliating or frightening or that causes pain to the child. Children shall never be locked in a room or closet.

c. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.

d. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.

e. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

109.12(3) *Children requiring special accommodations.* Reasonable accommodations, based on the special needs of the child, must be made in providing care to a child with a disability.

109.12(4) *Infant environment.*

a. An area shall be provided that is properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older.

b. Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

c. Highchairs or hook-on seats shall be equipped with a safety strap that shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

d. Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

e. The provider shall follow safe sleep practices for infants under one year of age.

(1) Infants shall always be placed on their backs for sleep.

(2) Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission (August 1, 2024) and ASTM federal standards (August 1, 2024).

(3) Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for infant sleeping, including but not limited to an infant seat, car seat, swing, or bouncy seat.

(4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

(5) No co-sleeping shall be allowed.

(6) Sleeping infants shall be actively observed by sight and sound.

(7) If an alternate sleeping position is needed, a signed physician or physician assistant authorization with statement of medical reason is required and an expiration date.

f. A crib or crib-like furniture that has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and that meets the current standards or recommendations from the U.S. Consumer Product Safety Commission (August 1, 2024) or ASTM International (August 1, 2024) for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or crib-like furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or crib-like furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

g. Infant walkers cannot be used.

h. All items used for sleeping must be used in compliance with manufacturer standards for age and weight of the child.

441—109.13(237A) Food services. Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

109.13(1) *Nutritionally balanced meals or snacks.* The center shall serve each child a full, nutritionally balanced meal or snack as defined by the CACFP guidelines (August 1, 2024) and shall ensure that staff provide supervision at the table during snacks and meals. Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

109.13(2) *Menu planning.* The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years (August 1, 2024). Menus shall be made available to parents and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of

causing choking in young children should not be served per CACFP FNS-877 (August 1, 2024). Exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

109.13(3) *Feeding of children under two years of age.*

a. All children under 12 months of age shall be fed on demand unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns (August 1, 2024). Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

b. Bottles or containers of infant foods should be warmed under running, warm tap water or by placing them in a container of water that is no warmer than 120°F (49°C). Bottles and infant foods should never be warmed in a microwave oven.

c. All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall not be placed in a crib or cot with a bottle or any other food item or left sleeping with a bottle or food item. Spoon feeding shall be adapted to the developmental capabilities of the child.

d. Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

e. Whole milk for children under two years of age who are not on formula or breast milk unless otherwise directed by a physician shall be used.

f. Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

109.13(4) *Food brought from home.*

a. The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines (August 1, 2024) are maintained.

b. The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

c. Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

d. Snacks that may not meet CACFP nutrition guidelines (August 1, 2024) may be provided by parents for special occasions such as birthdays or holidays.

109.13(5) *Food preparation, storage, and sanitation.* Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the CACFPs (August 1, 2024) and provide:

a. Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

b. Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

c. Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

d. Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

109.13(6) *Water supply.* The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

a. Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

b. When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

441—109.14(237A) Extended evening care. A center providing extended evening care between the hours of 9 p.m. and 5 a.m. shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

109.14(1) Facility requirements.

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene that the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

109.14(2) Activities.

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

441—109.15(237A) School-based before- and after-school and summer programs. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings is considered appropriate for use by a child care facility. Centers that operate in a school building shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the following considerations.

109.15(1) Infant-specific regulations outlined in paragraph 109.12(4) "e" and subrule 109.13(3) are not applicable.

109.15(2) Centers may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building.

109.15(3) Centers shall ensure that the indoor and outdoor space occupied by the center is sanitary, safe, and hazard-free. Outdoor space used for recreation during the school day is sufficient for use by the child care program.

109.15(4) Centers that serve only school-age children and that operate in a school building are exempted from testing for lead and carbon monoxide.

109.15(5) Personnel. For director requirements set forth in subrule 109.6(1), for centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience

working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.15(6) Child's file. All requirements under subrule 109.9(2) must be followed, but for a center serving school-age children that operates in the same school facility in which the child attends school, documentation shall include a statement signed by the parent that the immunization information is available in the school file.

441—109.16(237A) Get-well center. A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

109.16(1) *Staff requirements.*

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in rule 655—6.3(152).

109.16(2) *Health policies.*

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards (August 1, 2024), approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the department.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

(1) Admitting symptoms.

(2) Medications administered and time they were administered.

(3) Nutritional intake.

(4) Rest periods.

(5) Output.

(6) Temperature.

109.16(3) *Exceptions.* The following exceptions to this chapter shall be applied to get-well centers:

a. A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over two years of age.

b. All staff that have contact with children shall have a minimum of ten clock hours of special training in caring for mildly ill children.

c. There shall be 40 square feet of program space per child.

d. Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

e. Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age and shall be in separate rooms with full walls and doors.

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 121
“Early Childhood Iowa Initiative”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 256I
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 256I and 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 12, 2024
1 p.m.

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking implements the Early Childhood Iowa Initiative, which aims to empower individuals, communities, and state-level partners to achieve the desired results identified in Iowa Code section 256I.2. The desired results will be achieved as private and public entities work collaboratively. This initiative creates a partnership between communities and state level partners to support children zero through age five and their families. The role of the Early Childhood Iowa State Board, area boards, and other state and local government agencies is to provide support, leadership, and facilitation of the growth of individual, community, and state responsibility in addressing the desired results.

This rulemaking also implements 2024 Iowa Acts, Senate File 2385, which eliminated the Early Childhood Stakeholders Alliance.

Finally, this rulemaking is combined with the Red Tape Review process, which would have normally occurred in calendar year 2026.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
The rulemaking has no specific benefit other than implementing new legislation.

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:

Four rules and ten restrictive terms were eliminated via the Red Tape Review process.

- Qualitative description of impact:

Reference to the Early Childhood Stakeholders Alliance, which was statutorily eliminated, has been removed from the rules.

3. Costs to the State:

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

The Department has personnel and other administrative costs associated with implementing the initiative.

- Anticipated effect on state revenues:

There is no impact on state revenues.

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

Rulemaking is appropriate since part of the existing rules is no longer valid.

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:

None.

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

Rulemaking is appropriate since part of the existing rules is no longer valid.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 121 and adopt the following new chapter in lieu thereof:

CHAPTER 121 EARLY CHILDHOOD IOWA INITIATIVE

441—121.1(256I) Definitions. For the purpose of these rules, the following definitions apply:

“Community partners” means individuals, early childhood service providers, and staff of other programs or agencies that communicate, coordinate and collaborate with an area board.

“Designation” means the status awarded by the state board to an early childhood Iowa area meeting the criteria established by the state board.

“Early childhood Iowa area” or *“area”* means the same as defined in Iowa Code section 256I.1.

“Early childhood Iowa area board” or *“area board”* means the same as defined in Iowa Code section 256I.1.

“Early childhood Iowa fund” means a fund created in the state treasury from which moneys are distributed to early childhood Iowa areas for the purpose of supporting children and their families.

“Early childhood Iowa office” means a state unit within the department to coordinate the early childhood Iowa initiative.

“Early childhood Iowa state board” or *“state board”* means the state of Iowa’s early childhood Iowa board as appointed by the governor that meets the membership criteria of citizens and state agency directors as voting members and legislators as nonvoting members.

“Evidence-based” means that a program has completed a randomized control trial conducted by an independent researcher and has demonstrated positive results for children and families. “Evidence-based” may also include research conducted by the program that has been published in a peer-reviewed journal that also demonstrates positive results for children and families. To be evidence-based, the program must include stringent standards for program replication including standards for implementation and monitoring to ensure that the program is being operated with fidelity to the original model.

“Indicator” means a measure that indirectly quantifies the achievement of a result.

“Result” means the effect desired for Iowans.

“State agency” means a department of the executive branch including but not limited to the departments of economic development, education, health and human services, and workforce development.

441—121.2(256I) Early childhood Iowa state board responsibility.

121.2(1) The state board will provide leadership and coordination for the development of Iowa’s early care, health and education system in cooperation with area boards, community partners and other state agencies.

121.2(2) The state board will:

- a.* Develop and implement a process for designating area boards. The state board will review the process at the close of each designation cycle.
- b.* Adopt state-level indicators with input from area boards. The state board will report on indicators each fiscal year and compare the data against baseline data and data from prior fiscal years as available. Indicators will measure all result areas of the early care, health and education system.
- c.* Adopt minimum standards to promote equal access to services subject to the authority of the area boards.
- d.* Adopt guidelines and standards for services provided under a school ready children grant. All guidelines and standards will be found in the online toolkit available on department’s official website.
- e.* Further the development of an early childhood integrated data system across state agencies and other partners.
- f.* Develop guidance to identify and improve the quality of services in early care, health and education programs, including evidence-based practices.
- g.* Promote other measures to advance the initiative.

441—121.3(256I) Early childhood Iowa coordination staff. In consultation with the state board, the department will provide fiscal oversight of the early childhood Iowa initiative. The fiscal oversight measures are defined in 441—Chapter 122.

441—121.4(256I) Early childhood Iowa areas.

121.4(1) The state board will approve early childhood Iowa area boundaries and the creation of area boards. Minimum criteria for areas and approval of area boards are set forth in Iowa Code section 256I.6.

121.4(2) The state board may waive any of the minimum criteria referenced in Iowa Code section 256I.6, if it is determined that exceptional circumstances exist. The state board further defines exceptional circumstances to include when the proposed change of boundaries creates hardship that reduces performance or quality of services within the area. The area board must provide compelling documentation of the hardship and clearly document the impact to performance or quality of services or both.

These rules are intended to implement Iowa Code sections 256I.1 through 256I.11.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 156
“Payments for Foster Care”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 234.6

State or federal law(s) implemented by the rulemaking: Iowa Code section 234.38 and 2024 Iowa Acts, House File 2698

Public Hearing

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

November 12, 2024
1 to 2 p.m.

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

These proposed rules establish a rate of maintenance payment for foster family care. 2024 Iowa Acts, House File 2698, states that funds appropriated shall be used to increase foster care reimbursement rates by 5 percent over the rates in effect on June 30, 2024.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Licensed foster families receiving a monthly maintenance payment for foster family care will benefit.
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:
There is a 5 percent increase over the foster care reimbursement rates in effect on June 30, 2024.
 - Qualitative description of impact:
These additional funds will benefit foster families in Iowa. The funds will help the Department recruit additional families and retain currently licensed foster families.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

None were identified.

- Anticipated effect on state revenues:

Each percentage increase to the current per diem rates would cost the State of Iowa approximately \$65,000 (1 percent).

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

The Department would be less capable of recruiting new foster families and retaining current families.

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

None were identified.

6. Alternative methods considered by the agency:

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

None were identified.

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

These amendments are mandated by the Iowa Code.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Amend subrule 156.6(1) as follows:

156.6(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule:

<u>Age of child</u>	<u>Daily rate</u>
0 through 5	~~\$16.78~~ <u>\$17.62</u>
6 through 11	~~\$17.45~~ <u>\$18.32</u>
12 through 15	~~\$19.10~~ <u>\$20.06</u>
16 or over	~~\$19.35~~ <u>\$20.32</u>

ITEM 2. Amend rule 441—156.7(234) as follows:

441—156.7(234) Kinship caregiver payment.

156.7(1) A kinship caregiver payment is a monthly payment to financially support the care of a child in a kinship caregiver's home. If approved by the department, kinship caregiver payment will be provided for a period of up to ~~six~~ four months.

156.7(2) All of the following conditions apply:

a. For each eligible child living in a kinship placement, a caregiver will receive ~~up to \$310 (\$10 per day)~~ a monthly payment according to the basic rate schedule in subrule 156.6(1) as a result of a court-ordered placement.

b. The payment will begin after ~~two consecutive months~~ 14 days of the child's placement in the kinship caregiver's home. The ~~two-month~~ 14-day requirement is waived if the child enters the kinship caregiver's home immediately following a paid placement for at least 30 days.

c. The payment will continue for up to ~~six~~ four months.

d. and *e.* No change.

This rule is intended to implement Iowa Code section 232.102.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 1
“Administrative and Regulatory Authority”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A and 147

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 17A and 147

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking provides the public with information relating to the mission of the Board of Medicine. The rules describe the organization of the Board and its statutory authority to oversee the practice of medicine and enforce the minimum standards in the practice of medicine.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There are no costs to the public to comply with this rulemaking. The agency incurs costs in the form of staff to support the work of the Board. Staff salaries are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards. There are costs paid to the Board members to attend regular Board business in the form of a \$50 per diem for each Board member’s travel expenses.

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

The public benefits from the rulemaking. The Board’s work serves to protect public health and safety. This rulemaking provides an overview of the work the Board regularly engages in. Additionally, the rulemaking sets guidelines for the meetings and structure of the Board. The open-session meetings provide an opportunity for the public to participate in the discussion of matters of public concern.

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:

The Board licenses and regulates over 15,000 medical licenses. In order to regulate the profession as directed in the Iowa Code, administrative processes are needed to properly issue licenses, investigate complaints, and run audits on compliance with Board rules.

- Qualitative description of impact:

Iowa statutes require the regulation and licensing of medical professionals to ensure the health and safety of members of the public who are receiving services and care from the licensed professionals. This rulemaking provides the administrative and regulatory authority for the Board to ensure rules are being utilized and complied with by licensees.

3. Costs to the State:

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

There are no costs to the public to comply with this rulemaking. The agency incurs costs in the form of staff to support the work of the Board. Staff salaries are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards. There are costs paid to the Board members to attend regular Board business in the form of a \$50 per diem for each Board member's travel expenses.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues.

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

Costs related to this rulemaking are not generally incurred by the public. Licensees may incur costs related to initial and renewal licensing fees; duplicate certificates; or completing a physical, mental, substance abuse, or clinical competency examination as ordered by a board. The benefit of the rulemaking is achieved since Board administrative processes and expectations of licensees are established within the rulemaking in accordance with statute.

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

The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The Department has not identified any less costly or less intrusive methods for achieving the purpose of this rulemaking.

6. Alternative methods considered by the agency:

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

The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The Department has not identified any less costly or less intrusive methods for achieving the purpose of this rulemaking.

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

The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The Department has not identified any less costly or less intrusive methods for achieving the purpose of this rulemaking.

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?

These rules publicly outline administrative processes of the professional licensing boards. The rules apply equally to all businesses. If a small business identifies a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, it may utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 1 and adopt the following new chapter in lieu thereof:

CHAPTER 1
ADMINISTRATIVE AND REGULATORY AUTHORITY

653—1.1(17A,147) Definitions. The following definitions are applicable to the rules of the board of medicine:

“Acupuncture” means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

“Acupuncturist” means a person licensed to practice acupuncture in this state.

“Alternate member” means a person who is qualified under Iowa Code section 148.2A to substitute for a board member who is disqualified or becomes unavailable for a contested case hearing. An alternate board member is deemed a member of the board only for the hearing panel(s) for which the alternate board member serves.

“Board” means the board of medicine of the state of Iowa.

“Department” means the Iowa department of inspections, appeals, and licensing.

“Director” means the director of the department.

“Disciplinary proceeding” means any proceeding under the authority of the board pursuant to which licensee discipline may be imposed.

“License” means a certificate issued to a person licensed to practice medicine and surgery, osteopathic medicine and surgery, or acupuncture under the laws of the state of Iowa.

“Licensee” means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, or acupuncture under the laws of the state of Iowa.

“Licensee discipline” or *“discipline”* means any sanction the board may impose upon its licensees for conduct that threatens or denies citizens of this state a high standard of professional care.

“Malpractice” means any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care by a physician in the practice of the physician’s profession.

“Medical practice Acts” refers to Iowa Code chapters 147 and 148.

“Order” means a requirement, procedure or standard of specific or limited application adopted by the board relating to any matter the board is authorized to act upon, including the professional conduct of licensees and the examination for licensure and licensure of any person under the laws of this state.

“Peer review” means evaluation of professional services rendered by a professional practitioner.

“Peer reviewer(s)” means one or more persons acting in a peer review capacity who have been appointed by the board for such purpose.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery under the laws of this state.

“Practice of acupuncture” means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medical concepts.

“The practice of medicine and surgery” means holding one’s self out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition and who shall either offer or undertake, by any means or methods, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition. This rule shall not apply to licensed podiatrists, chiropractors, physical therapists, nurses, dentists, optometrists, acupuncturists, pharmacists, and other licensed health professionals who are exclusively engaged in the practice of their respective professions.

“Prescription drugs” means drugs, medicine and controlled substances that by law can only be prescribed for human use by persons authorized by law.

“Profession” means medicine and surgery, osteopathic medicine and surgery, or acupuncture.

“Respondent” means a licensee charged by the board in a complaint and statement of charges with violations of statutes or rules relating to the practice of medicine and surgery, osteopathic medicine and surgery, or acupuncture.

“Rule” means a regulation, requirement, procedure, or standard of general application prescribed by the board relating to either the administration or enforcement of Iowa Code chapters 147, 148, and 148E.

653—1.2(17A) Purpose of board. The purpose of the board is to administer and enforce the provisions of Iowa Code chapters 147, 148, 148E, and 272C with regard to the practice of medicine and surgery, osteopathic medicine and surgery, and acupuncture.

653—1.3(17A) Organization of board.

1.3(1) The board:

a. Makes policy relative to matters involving medical and acupuncture education, licensure, practice, and discipline.

b. Conducts business according to board-approved policy.

c. Elects a chairperson, vice chairperson and a secretary from its membership at the last regular board meeting prior to May 1 or at another date in April scheduled by the board.

d. Has the authority and powers conferred in Iowa Code chapters 17A, 147, 148 and 272C and may establish committees of the board, the members of which, except for the executive committee, shall be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include:

(1) Executive committee. The membership is composed of the elected officers of the board and two at-large members appointed by the chairperson. At least one public member is appointed to the executive committee. The executive committee duties may include but are not limited to:

1. Guidance and supervision of the executive director.
 2. Budgetary review and recommendations to the board.
 3. Review and recommendations to the board on rules and legislative proposals.
 4. Study and recommendations to the board on practice issues and policy.
 - (2) Screening committee. The committee reviews complaints and makes recommendations to the board on appropriate action including further investigation or referral to the board for closure.
 - (3) Licensure committee. Its duties may include:
 1. Recommending appropriate action on completed applications for licensure.
 2. Conducting interviews with applicants when appropriate.
 3. Reviewing licensure examination matters.
 4. Reviewing and recommending to the board appropriate changes in licensure application forms.
 5. Reviewing and making recommendations to the board regarding volunteer physician applicants who wish to participate in the state-indemnified volunteer physician program and who are under investigation or who have or have had disciplinary action against a license in the present or in the past.
 6. Making recommendations on licensure policy issues.
 - (4) Monitoring committee. The committee oversees the monitoring of licensees under board orders and makes recommendations to the board on these matters.
 - e. Establishes, in accordance with Iowa Code section 148.2A, a pool of alternate board members.
- 1.3(2)** A majority of the members of the board shall constitute a quorum. Official action, including filing of formal charges or imposition of discipline, requires a majority vote of members present.

653—1.4(17A) Official communications. All official communications, including submissions and requests, should be addressed to the Executive Director, Iowa Board of Medicine, 6200 Park Avenue, Suite 100, Des Moines, Iowa 50321.

653—1.5(17A) Office hours. The office of the board is open for public business from 8 a.m. to 4:30 p.m., Monday through Friday of each week, except holidays.

653—1.6(17A) Meetings. The board shall meet at least six times per year. Dates and location of board meetings may be obtained from the board's office or on the board's website at www.dial.iowa.gov. Except as otherwise provided by statute, all board meetings are open, and the public is permitted to attend the meetings.

653—1.7(17A,272C) Adoption of uniform and model rules. The board hereby adopts by reference the following:

1. Uniform Rules on Agency Procedure, 481—Chapter 2, 481—Chapter 3, 481—Chapter 4, 481—Chapter 5, and 481—Chapter 6.
 2. Military Service, Veteran Reciprocity, and Spouses of Active-Duty Service Members, 481—Chapter 7.
 3. Licensing and Child Support Noncompliance, Student Loan Repayment Noncompliance, and Nonpayment of State Debt, 481—Chapter 8.
 4. Model Rules for Use of Criminal Convictions in Eligibility Determinations and Initial Licensing Decisions, 481—Chapter 502.
 5. Model Rules for Licensee Review Committee, 481—Chapter 505.
 6. Model Rules for Contested Cases Before Licensing Boards, 481—Chapter 506.
- These rules are intended to implement Iowa Code chapters 17A and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapters 2, 3, 12, 14, 15, 18, 25
“Public Records and Fair Information Practices; Waivers; Nonpayment of State Debt; Iowa Physician Health Committee—Iowa Physician Health Program; Child Support Noncompliance; Military Service and Veteran Reciprocity; Contested Case Proceedings”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 22, 147, 148, 148E, 252J, 272C and 272D

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 17A, 22, 147, 148, 148E, 252J and 272D and section 272C.3

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa
Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: Emily.deronde@dia.iowa.gov

Purpose and Summary

In light of the Board of Medicine’s realignment with the Department resulting from 2023 Iowa Acts, Senate File 514, the Board finds it is unnecessary and unreasonably duplicative to repromulgate these chapters. It is the Board’s intent to rely on the model chapters of the Department[481]. The proposed rescission of these chapters is in line with the stated goal of Iowa Code chapter 17A to “simplify government by assuring a uniform minimum procedure to which all agencies will be held in the conduct of their most important functions.”

Chapter 2 provides guidance on public records and how individuals can receive public records from the Board. The chapter is substantially similar to 481—Chapter 5, which the Board will adopt by reference and utilize for the purposes of public records.

Chapter 3 provides guidance to the public and licensees on when and how to request a waiver of an administrative rule. The chapter is substantially similar to 481—Chapter 6, which will be utilized by the Board for waivers.

Chapter 12 implements Iowa Code chapter 272D, which provides for procedures when a license may be denied, suspended or revoked for nonpayment of a state debt and child support obligations.

This chapter is substantially similar to 481—Chapter 8, which will be utilized by the Board for these procedures.

Chapter 14 creates the Iowa Physician Health Program and Committee. This is a confidential program to ensure that licensees are safe to practice their profession. The program provides ongoing monitoring for eligible participants. This chapter is substantially similar to 481—Chapter 505, which will be utilized by the Board for its impaired practitioner program for physicians.

Chapter 15 implements Iowa Code chapter 252J and provides the process for taking action against a licensee if the licensee is not compliant with child support orders. This chapter is substantially similar to 481—Chapter 8, which will be utilized by the Board to carry out these statutory requirements.

Chapter 18 provides a mechanism for United States veterans and spouses of veterans to apply for and be granted reciprocity for licensing requirements in the state of Iowa. This chapter is substantially similar to 481—Chapter 7, which the Board will adopt by reference in place of this chapter.

Chapter 25 provides the licensee an outline of how a contested case proceeding is initiated and the rights and responsibilities of the licensee during that process. The Board intends to rescind this chapter and adopt by reference 481—Chapter 506, which is a model rules chapter and substantially similar to this chapter.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There are no costs associated with this proposed rulemaking. The Board is leveraging this opportunity to remove duplication among administrative rules, eliminate the obsolete provisions of the rules, and streamline provisions into a single set of chapters in accordance with Executive Order 10. The Board intends to adopt by reference 481—Chapters 5, 6, 7, 8, 505, and 506, which are model rules chapters, to apply to multiple licensing boards within the Department.

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

Interested stakeholders will benefit from the removal of these chapters since the removal will prevent duplication within the rules and allow all licensing boards to utilize the same model rules. The Board is leveraging this opportunity to remove duplication among administrative rules, eliminate the obsolete provisions of the rules, and streamline provisions into a single set of chapters in accordance with Executive Order 10. The Board intends to adopt by reference 481—Chapter 5, 481—Chapter 6, 481—Chapter 7, 481—Chapter 8, 481—Chapter 505, and 481—Chapter 506, which are model rules chapters, to apply to multiple licensing boards within the department.

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:

There is no impact identified for the rescission of these chapters.

- Qualitative description of impact:

There is no impact identified for the rescission of these chapters.

3. Costs to the State:

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

There are no implementation or enforcement costs anticipated by the agency or any other agency.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues.

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

The benefit of the proposed rulemaking compared to inaction is to avoid duplication and redundancy in the Iowa Administrative Code.

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

No alternative methods exist to achieve the same purpose.

6. Alternative methods considered by the agency:

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

No alternative methods were identified or considered.

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

No alternative method was identified that would be any more efficient than this method of rulemaking.

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?

The proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

- ITEM 1. Rescind and reserve **653—Chapter 2.**
- ITEM 2. Rescind and reserve **653—Chapter 3.**
- ITEM 3. Rescind and reserve **653—Chapter 12.**
- ITEM 4. Rescind and reserve **653—Chapter 14.**
- ITEM 5. Rescind and reserve **653—Chapter 15.**
- ITEM 6. Rescind and reserve **653—Chapter 18.**
- ITEM 7. Rescind and reserve **653—Chapter 25.**

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 8
“Fees”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147, 148 and 272C

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147, 148 and 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

The purpose of this proposed rulemaking is to establish fees for physicians, acupuncturists, and genetic counselors. Fees include initial licensing, renewal, late fees, and reinstatement fees.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

Costs are not generally incurred by the public related to Chapter 5. Licensees incur costs through the licensing fees as established in this chapter, which include fees related to applications for initial licensing, renewal of licenses, late renewal of licenses, temporary licenses (if permitted by statute), reactivation of a license, purchasing a duplicate certificate, and returned check fees.

The professional licensing fees go to the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557, to support the work of the boards. Fees provide support for all functions that are within the authority of boards, including licensing, investigations, continuing education, administrative support to boards including rulemaking and rule waivers, board discipline, outreach to professional associations and other members of the public, disciplinary hearing fees, examination fees (if applicable), and verification of license fees.

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

Licensees benefit from this chapter because it establishes set amounts for licensing fees for the profession.

The Department benefits because the licensing fees are paid to the fund to cover the costs of the operations of the regulated professional licensing boards.

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:

Licensees must pay a fee at the time of initial application for license as well as at renewal. The licensing fees are paid into the fund, which funds the operations of the boards. A cost comparison of license fees to nearby states can be found at www.fsmb.org/siteassets/advocacy/regulatory/licensure/licensure-fees-and-requirements-not-including-usmle-or-nbome-examination-fees.pdf.

- Qualitative description of impact:

A review of licensing and renewal fees in surrounding states shows that Iowa's fees are generally in line with the other states. The fees are necessary to provide funds to support Board of Medicine operations so that the Board can ensure Iowans receive competent and safe services. The Board is participating in the licensing fee study pursuant to 2024 Iowa Acts, Senate File 2385.

3. Costs to the State:

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

Staff process licenses, provide administrative support to the Board for the decisions the Board is authorized to make pursuant to the Iowa Code, investigate complaints, assist with disciplinary action when needed, and monitor licensees under Board order or in confidential health monitoring programs. Staff salaries to support the work of the Board are covered by the fund. There are approximately 15.0 full-time equivalent (FTE) positions that support the work of the Board. The board licenses and regulates over 17,000 licensees. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues from this rulemaking. Staff salaries to support the work of the Board are covered by the fund. Licensing fees are paid into the fund to cover the operation costs of the boards.

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

The licensing fees are paid into the fund to cover the costs of operation of the professional licensing boards. An alternative to licensing fees would be reducing or eliminating the fee or license requirement. Without the licensing fee, the boards would not have the financial resources necessary to carry out their work to protect the public's health and safety.

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

A less restrictive alternative would be to lower licensing fees or eliminate licensure for specific professions. Less restrictive forms of regulation include a registration, certification, or registry. There are typically fewer requirements to a registration, certification or registry, which means operational costs, and therefore fees, can be lowered. While these are options that exist for consideration, the Board believes that Iowa's regulatory scheme, as it exists today, is important and necessary because it provides safeguards to the public. Fiscal year 2024 was the first fiscal year where professional licensing board fees were collectively pooled in the fund to support the cost of regulating the professions. This new model may allow for additional assessment of licensing board budgets and operational needs.

The Board is participating in the licensing fee study pursuant to 2024 Iowa Acts, Senate File 2385.

The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards.

6. Alternative methods considered by the agency:

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

A less restrictive alternative would be to lower licensing fees or eliminate licensure for specific professions. Less restrictive forms of regulation include a registration, certification, or registry. There are typically fewer requirements to a registration, certification or registry, which means operational costs, and therefore fees, can be lowered.

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

The Board believes that Iowa's regulatory scheme, as it exists today, is important and necessary because it provides safeguards to the public.

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?

The boards believe the fees for licensing should be the same for each licensee in a particular profession. If the individual licensee finds a rule to be overly burdensome and the goals of which could be achieved in a manner that results in less impact on the small business, the licensee utilizes the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 8 and adopt the following **new** chapter in lieu thereof:

CHAPTER 8 FEES

653—8.1(147,148,272C) Definitions.

"Board" means the Iowa board of medicine.

"Online transaction fee" means a fee of \$7 assessed by the board for completing an online purchase. The online transaction fee is in addition to the actual service provided.

653—8.2(147,148,272C) Application and licensure fees for acupuncturists.

8.2(1) The fees are as follows:

- a. Initial application fee for licensure as an acupuncturist, \$300.
- b. Reactivation of application for licensure, \$100.
- c. Renewal fee for licensure as an acupuncturist, \$300.
- d. Fee for the evaluation of the fingerprint packet and the division of criminal investigation (DCI) and Federal Bureau of Investigation (FBI) criminal history background checks, \$45.
- e. Fee for reapplication of an acupuncture license, \$400.
- f. Penalty for failure to renew before expiration, \$50.

8.2(2) Upon written request and payment of the designated fee, the board shall provide the following information about the status of an acupuncturist's license or acupuncturist's past registration:

- a.* Certified statement that verifies the status of licensure or past registration in Iowa that requires the board seal or a letter of good standing, \$25.
- b.* Verification of the status of licensure or past registration in Iowa that does not require a certified statement or letter, \$20.

653—8.3(147,148,272C) Interstate medical licensure compact (IMLC) fees.

8.3(1) *Service fee for an application for an IMLC letter of qualification.* The service fee is paid directly to the interstate medical licensure compact commission. The interstate commission retains a portion of this service fee and remits a portion of this service fee to the board. The service fee paid to the interstate commission includes the \$45 fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI.

8.3(2) *Licensure fee for an Iowa license issued through the IMLC.* The licensure fee is paid directly to the interstate medical licensure compact commission. An applicant shall pay a licensure fee of \$450 plus a service fee retained by the interstate commission.

8.3(3) *Licensure fee for renewal of active Iowa license issued through the IMLC.* The licensure fee is paid directly to the interstate medical licensure compact commission. The licensee shall pay the licensure fee described in subparagraph 8.4(1)“c”(1) plus a service fee retained by the interstate commission. If the license is not renewed prior to expiration, the licensee will incur a penalty as described in paragraph 8.4(1)“d.”

653—8.4(147,148,272C) Application and licensure fees to practice medicine and surgery or osteopathic medicine and surgery or administrative medicine.

8.4(1) Fees for permanent licensure.

a. Initial licensure, \$450 plus the \$45 fee for evaluation of the fingerprint packet and the criminal history background checks by the DCI and FBI.

b. Reactivation of application for licensure, \$150.

c. Renewal of an active license to practice.

(1) \$550 if renewal is made via paper application, or \$450 if renewal is made via online application, per biennial period or a prorated portion thereof if the current license was issued for a period of less than 24 months.

(2) No renewal fee if a physician was on active duty in the U.S. armed forces, reserves or national guard during the renewal period. “Active duty” means full-time training or active service in the U.S. armed forces, reserves or national guard.

d. Penalty for failure to renew before expiration, \$100 per calendar month after the expiration date of the license up to \$200.

e. Placing a license on inactive status or allowing a license to become inactive, no fee.

f. Reactivation of a license to practice one year or more after becoming inactive, \$500 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

g. Reactivation of a license within one year of becoming inactive, \$550 except when the license in the most recent license period had been granted for less than 24 months. In that case, the reinstatement fee is prorated according to the date of issuance and the physician’s month and year of birth.

8.4(2) Fees for resident physician licensure.

a. Application for a resident physician license, \$100 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Extension of a resident physician license, \$25.

c. Late fee for extension of a resident physician license, \$50, to be paid in addition to the extension fee.

8.4(3) Fees for special physician licensure.

a. Application for a special physician license, \$300 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a special physician license, \$200.

8.4(4) Fees for temporary physician licensure.

a. Application for a temporary physician license, \$100 plus the \$45 fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a temporary physician license, \$50.

8.4(5) Fee for photocopy of a licensure application, \$20.

8.4(6) Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, \$45.

653—8.5(147,148,272C) Fees for verification of physician licensure and certification of examination scores.

8.5(1) *Verification fees.*

a. Physicians shall use VeriDoc to secure a certified statement that verifies Iowa licensure status for any state medical board that accepts VeriDoc. VeriDoc is accessible at www.veridoc.org. The fee for this service is \$30.

b. A physician who needs a certified statement that verifies Iowa licensure status for a state medical board that does not accept verification from VeriDoc shall make a written request for a certified statement with payment of a \$30 verification fee to the board of medicine. The board shall provide a certified statement that verifies Iowa licensure status to the nonaccepting state medical board.

c. The fee for verification of Iowa licensure status that does not require a certified statement or letter is \$15.

d. The board provides an electronic verification service whereby users can input the licensee's license number to learn the licensee's current licensure status. There is no fee for this service. The board shall provide a license number for an individual caller to use in the automated telephone or electronic verification service. Businesses that utilize verifications will be required to utilize the automated telephone or electronic verification service or the alternative outlined in paragraph 8.5(1) "*c.*"

8.5(2) *Fees for certification of physician examination scores.* Upon request and payment of the designated fee, the board may provide certification of scores of an examination given by the board in Iowa as permitted under Iowa Code section 147.21 and 653—paragraph 2.13(2) "*f.*" The scores available from the board are those from examinees who took the state-constructed examination.

a. Certified statement of grades attained by examination, \$45.

b. Certified statement of grades attained by examination including examination history or additional documentation, \$55.

653—8.6(147,148,272C) Public records.

8.6(1) *Public records available at no cost.* The following records are available at no cost to the public:

a. Public action taken by the board against a licensee may be found under the licensee's name on the board's website under "Find A Physician." Public actions are posted on the board's website within approximately one week after the board has taken action.

b. Electronic files of press releases, statements of charges, final orders and consent agreements from each board meeting are available on the board's website.

8.6(2) *Purchase of public records.* Public records are available according to 481—Chapter 5.

653—8.7(147,148,272C) Licensee data list. A data list of all physicians and acupuncturists includes the following information about each licensee: full name, year of birth, work address and telephone number (or other contact information on file if licensee's work address and telephone number are not

available), Iowa county (if applicable), medical school (if applicable), year of graduation from medical school (if applicable), two medical specialties (if available), license issue date, license expiration date, license number, license type, license status, and an indicator of whether the board has taken any public action on the license. There is no fee for an electronic file of this list. A printed copy of the data list is available for a fee.

653—8.8(147,148,272C) Returned checks. The board will charge a fee of \$25 for a check returned for any reason. If a license had been issued by the board office based on a check that is later returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification of the returned check by certified mail, the licensee shall be subject to disciplinary action for noncompliance with board rules.

653—8.9(147,148,272C) Copies of the laws and rules. Electronic copies of laws and rules pertaining to the practice of medicine or acupuncture are available at www.legis.iowa.gov at no cost. Printed copies of these laws and rules are available for a fee.

653—8.10(147,148,272C) Refunds. Application and licensure fees will be collected by the board and are not refundable except by board action in unusual instances.

653—8.11(17A,147,148,272C) Waiver prohibited. Licensure and examination fees in this chapter are not subject to waiver.

653—8.12(8,147,148,272C) Monitoring fee. The board may require payment of up to \$300 per quarter to cover the board's expenses to monitor a licensee's compliance with a settlement agreement or final decision and order.

653—8.13(147,148,272C) Application and licensure fees for genetic counselors.

8.13(1) The fees are as follows:

- a.* Initial application fee for licensure, \$200.
- b.* Reactivation of application for licensure, \$100.
- c.* Renewal of an active license, \$200.
- d.* Penalty for failure to renew before expiration, \$50.
- e.* Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, \$45.
- f.* Fee for reactivation of a license, \$300.

8.13(2) Upon written request and payment of the designated fee, the board shall provide the following information about the status of a genetic counselor's license:

- a.* Certified statement that verifies the status of licensure in Iowa that requires the board seal or a letter of good standing, \$25.
- b.* Verification of the status of licensure in Iowa that does not require a certified statement or letter, \$20.

These rules are intended to implement Iowa Code sections 147.11, 147.80, 148.3, 148.5, 148.10, and 148.11.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 9
“Permanent and Administrative Medicine Physician Licensure”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147 and 148

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147 and 148

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking sets minimum standards for entry into the medical profession. Iowa residents, licensees and employers benefit from the rulemaking since it articulates the processes by which individuals apply for licensure as a physician in the state of Iowa, as directed by statute. This includes the processes for initial licensure, renewal and reactivation. These requirements ensure public safety by ensuring that any individual entering the profession has minimum competency through educational qualifications and examination requirements.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There is no direct cost to the general public, but there is a cost to the applicant since complying with the minimum requirements to enter into the profession is at the expense of the licensee.

The licensee would also have costs related to educational requirements and examination requirements. The Board of Medicine has not identified an exact cost of education for this field since it varies depending on the school the licensee chooses to attend to meet those requirements.

Board staff review applications for initial and renewal licenses, answer inquiries on licensing and field phone calls. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The public and professionals benefit from the proposed rules. Establishing minimum licensing requirements ensures that practitioners are competent to practice. Without having an established threshold for entry into the profession, individuals who are not appropriately trained could cause serious harm to the public during their practice. Physicians require certain skills and training to effectively help and treat their patients.

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:

Educational institutions provide the academic training for physicians to obtain their license in the state of Iowa. Additional private industries and educational institutions provide examinations and materials for preparation for the examinations. Because the cost of education is so variable depending on the institution the person attends, the Board is unable to put an exact cost on the cost of education or examination preparation.

Licensing fees are \$450 for initial licensing and \$450 for renewal for a single-state Iowa license and an Interstate Medical License Compact license.

- Qualitative description of impact:

Establishing minimum requirements for licensure ensures safety for the licensee and consumer. The cost of inaction would be increasing the potential for injury to the public by a licensee who is not qualified to perform the work in the field.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage Board activities, which include managing applications for initial licenses, renewals and reinstatements. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

- Anticipated effect on state revenues:

Costs associated with implementing this rulemaking are paid by individual licensees or establishments, not the State. This rulemaking has no anticipated impact on state revenues.

Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario. In addition, the chapter provides consistency related to the licensure of physicians in other states, which makes obtaining licensure in multiple states simpler for applicants.

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

The Board has not identified a more cost-effective alternative to the licensure of physicians. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario. In addition, the chapter provides consistency related to the licensure of physicians in other states, which makes obtaining licensure in multiple states simpler for applicants.

6. Alternative methods considered by the agency:

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

The Board has not identified a more cost-effective alternative to the licensure of physicians. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of physicians. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario. In addition, the chapter provides consistency related to the licensure of physicians in other states, which makes obtaining licensure in multiple states simpler for applicants.

Due to the state government realignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort. The Department is actively pursuing a single licensing platform to assist in standardizing licensing.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 9 and adopt the following **new** chapter in lieu thereof:

CHAPTER 9

PERMANENT AND ADMINISTRATIVE MEDICINE PHYSICIAN LICENSURE

653—9.1(147,148) Definitions.

“ABMS” means the American Board of Medical Specialties.

“ACGME” means the Accreditation Council for Graduate Medical Education.

“AMA” means the American Medical Association.

“Any jurisdiction” means any state, the District of Columbia or territory of the United States of America or any other nation.

“Any United States jurisdiction” means any state, the District of Columbia or territory of the United States of America.

“AOA” means the American Osteopathic Association.

“Applicant” means a person who seeks authorization to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine in this state by making application to the board, or a physician who seeks licensure through the IMLC.

“Approved abuse education training program” means a training program using a curriculum approved by the abuse education review panel of the department of health and human services or a training program offered by a hospital, a professional organization for physicians, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“Board” means the board of medicine.

“Board-approved resident training program” means a hospital-affiliated graduate medical education program accredited by ACGME, AOA, RCPSC, or CFPC at the time the applicant is enrolled in the program.

“Candidate” means a person who applies to sit for an examination administered by the board or its designated testing service.

“Category 1 credit” means any formal education program that is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“CFPC” means the College of Family Physicians of Canada.

“COCA” means the Commission on Osteopathic College Accreditation.

“COMLEX” means the Comprehensive Osteopathic Medical Licensing Examination.

“Committee” means the licensure committee of the board.

“COMVEX-USA” means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America.

“Core credentials” means those documents that demonstrate the applicant’s identity, medical training and practice history.

“Current, active status” means a license that is in effect and grants the privilege of practicing administrative medicine, medicine and surgery or osteopathic medicine and surgery, as applicable.

“ECFMG” means the Educational Commission for Foreign Medical Graduates.

“Expedited license” means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the IMLC.

“FCVS” means the Federation Credentials Verification Service.

“FLEX” means the Federation Licensing Examination.

“Foreign medical school,” also known as an “international medical school,” means a medical school that is located outside of any United States jurisdiction or Canada.

“FSMB” means the Federation of State Medical Boards.

“IMLC” means the Interstate Medical Licensure Compact enacted in Iowa Code chapter 147B.

“Inactive license” means any license that is not in current, active status.

“Incidentally called into this state in consultation with a physician and surgeon licensed in this state” as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.

3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed physician as to the care that should be provided, but the consulting physician may not personally perform procedures, write orders, or prescribe for the patient.

4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.

5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient's care.

"Initial license" means the first permanent or administrative medicine license granted to a qualified individual.

"International medical school," also known as a "foreign medical school," means a medical school that is located outside of any United States jurisdiction or Canada.

"Interstate commission" means the interstate commission created pursuant to Iowa Code chapter 147B.

"LCME" means Liaison Committee on Medical Education.

"LMCC" means enrollment in the Canadian Medical Register as Licentiate of Medical Council of Canada with a certificate of registration as proof.

"MCCEE" means the Medical Council of Canada Evaluating Examination.

"Medical degree" means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from a foreign medical school.

"National Practitioner Data Bank" is a national data bank of disciplinary actions taken against health professionals, including physicians.

"NBME" means the National Board of Medical Examiners.

"NBOME" means the National Board of Osteopathic Medical Examiners.

"Observer" means a person who is not enrolled in an LCME- or COCA-accredited medical school or osteopathic medical school, who observes care to patients in Iowa for a defined period of time and for a noncredit experience, and who is supervised and accompanied by an Iowa-licensed physician as defined in subrule 9.2(3). An observer shall not provide or direct hands-on patient care, regardless of the observer's level of training or supervision. The supervising physician may authorize an observer to read a chart, observe a patient interview or examination, or witness procedures, including surgery. An observer shall not chart; touch a patient as part of an examination; conduct an interview; order, prescribe or administer medications; make decisions that affect patient care; direct others in providing patient care; or conduct procedures, including surgery. Any of these activities requires licensure to practice in Iowa. An unlicensed physician observer or a medical student observer who is not enrolled in an LCME- or COCA-accredited medical school may touch a patient to verify a physical finding in the immediate presence of a physician but shall not conduct a more inclusive physical examination.

An unlicensed physician observer may:

1. Participate in discussions regarding the care of individual patients, including offering suggestions about diagnosis or treatment, provided the unlicensed physician observer does not direct the care; and

2. Elicit information from a patient provided the unlicensed physician observer does not actually perform a physical examination or otherwise touch the patient.

"Permanent licensure" means licensure granted after review of the application and core credentials to determine that the individual is qualified to enter into clinical practice.

"Practice" means the practice of medicine and surgery or osteopathic medicine and surgery.

"Primary source verification" means:

1. Verification of the authenticity of documents with the original source that issued the document.

2. Original source verification by another jurisdiction's physician licensing organization.

3. Original source verification by the FSMB's Federation Credentials Verification Service.

"RCPSC" means the Royal College of Physicians and Surgeons of Canada.

“Reactivation” means the process for returning an inactive license to current, active status.

“Relinquishment” means that a person’s permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine is deemed abandoned if the person fails to renew or reactivate the license within five years after its expiration. A license that has been relinquished is no longer valid or renewable. Relinquishment is not disciplinary in nature.

“Resident physician” means a physician enrolled in an internship, residency or fellowship.

“Resident training program” means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

“Service charge” means the amount charged for making a service available online and is in addition to the actual fee for a service itself.

“SPEX” means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction.

“Terminated license” means a nondisciplinary process by which an Iowa license issued through the Interstate Medical Licensure Compact is no longer eligible for renewal. A compact license is terminated when a licensee no longer meets the IMLC qualifications. A terminated IMLC license may not be reinstated.

“Uniform application for physician state licensure” means a web-based application that is intended to standardize and simplify the licensure application process for state medical licensure.

“USMLE” means the United States Medical Licensing Examination.

653—9.2(147,148) General licensure provisions.

9.2(1) *Licensure required.* Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in subrule 9.2(2).

9.2(2) *Licensure not required.* The following persons are not required to obtain a license to practice in Iowa:

a. Those persons described in Iowa Code section 148.2(1) through 148.2(5). A medical student or osteopathic medical student in an international medical school may not take on the role of a medical student in the patient care setting unless the student is enrolled in the University of Iowa’s Carver College of Medicine or in Des Moines University’s College of Osteopathic Medicine; however, an international medical student or graduate of an international medical school not enrolled at either of these institutions may be an observer as defined in rule 653—9.1(147,148).

b. Those persons who are incidentally called into this state in consultation with a physician or surgeon licensed in this state as described in Iowa Code section 148.2(5) and as defined in rule 653—9.1(147,148).

c. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa on a temporary basis to aid disaster victims at the time of a disaster in accordance with Iowa Code section 29C.6.

d. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come to Iowa to participate in further medical education may participate in patient care under the request and supervision of the patient’s Iowa-licensed physician in charge of the education. The Iowa-licensed physician shall retain the primary responsibility for management of the patient’s care.

e. Physicians and surgeons who hold a current, active license in good standing in another United States jurisdiction and who come into Iowa to serve as expert witnesses as long as they do not provide treatment.

f. Physicians and surgeons from out of state who hold a current, active license in good standing in another United States jurisdiction and who accompany one or more individuals into Iowa for the purpose of providing medical care to these individuals on a short-term basis; e.g., a team physician for an out-of-state college football team that comes into Iowa for a game.

g. Physicians and surgeons who come to Iowa to observe patient care and who do not provide or direct hands-on patient care.

h. Visiting resident physicians who come to Iowa to practice as part of their resident training program if under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (more information can be found in rule 653—10.5(147,148)).

9.2(3) *Supervision of an observer.* An Iowa-licensed physician who supervises an observer shall accompany the observer and solicit consent from each patient, where feasible, for the observation. The physician shall inform the patient of the observer's background; e.g., a high school student considering a medical career or a medical graduate who is working on licensure. The supervising physician ensures that the observer remains within the scope of an observer as defined in rule 653—9.1(147,148).

653—9.3(147,148) Eligibility for licensure.

9.3(1) *Requirements.* To be eligible for permanent or administrative medicine licensure, an applicant shall:

a. Fulfill the application requirements specified in rule 653—9.4(147,148).

b. Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board shall be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for the educational institutions granting degrees in medicine and surgery; and
2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant shall meet one of the following requirements:

1. Hold a valid certificate issued by ECFMG;
2. Pass the MCCEE;
3. Have successfully completed a fifth pathway program established in accordance with AMA criteria;

4. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and have successfully completed three years of resident training in a program approved by the board; and have submitted evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction; or

5. Have successfully passed either a basic science examination administered by a United States or Canadian medical licensing authority or SPEX; and hold board certification by a specialty board approved by ABMS or AOA; and submit evidence of five years of active practice without restriction as a licensee of any United States or Canadian jurisdiction.

c. Have successfully completed one year of resident training in a hospital-affiliated program approved by the board at the time the applicant was enrolled in the program. An applicant who is a graduate of an international medical school must have successfully completed 24 months of such training.

(1) For those required to have 12 months of training, the program shall have been 12 months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board. For those required to have 24 months of training, the program shall

have been 24 continuous months of progressive training in not more than two specialties and in not more than two programs approved for resident training by the board.

(2) Resident training approved by the board must be accredited by an accrediting agency recognized by the board for the purpose of accrediting resident training programs.

(3) The board approves resident training programs accredited by:

1. ACGME;
2. AOA;
3. RCPSC; and
4. CFPC.

(4) The board may accept resident training that is not accredited as specified in subparagraph 9.3(1)“c”(3) on a case-by-case basis. In making this determination, the board may consider any relevant factors, including but not limited to the following:

1. The length of time the program has been in existence;
2. The location of the program;
3. The institution or organization that administers the program;
4. The reason that the program is not accredited; and
5. Whether the program is accredited or recognized by any agency other than those listed in subparagraph 9.3(1)“c”(3).

(5) The board may accept each 12 months of practice as a special licensee as equivalent to one year of resident training in a hospital-affiliated program approved by the board.

(6) The board may accept a current, active ABMS or AOA board certification obtained through an alternate pathway as equivalent to resident training in a hospital-affiliated program approved by the board. The alternate pathway must be a minimum of 24 months completed at an institution with a program approved by the board as specified in subparagraph 9.3(1)“c”(3).

d. Pass one of the licensure examinations or combinations as prescribed in rule 653—9.7(147,148).

9.3(2) *Exceptions to the eligibility requirements.*

a. A military service applicant or a veteran may apply for credit for verified military education, training, or service toward any experience or educational requirement for permanent licensure under this subrule or may be eligible for permanent licensure through reciprocity as specified in 653—Chapter 18.

b. A physician who holds a valid Letter of Qualification asserting eligibility for licensure through the IMLC is eligible for a permanent Iowa medical license.

653—9.4(147,148) Licensure application.

9.4(1) *Requirements.* To apply for licensure, an applicant shall:

a. Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) as specified in 653—paragraph 8.4(1)“a”; and

b. Complete and submit the application and forms provided by the board, including required core credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant that has been signed by the applicant in the physical presence of a notary public.

c. Pass one of the examinations as prescribed in rule 653—9.7(147,148) and authorize the testing authority to verify scores.

9.4(2) *Application.* The application shall require the following information:

a. Full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

b. A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

c. A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application.

d. A certified statement of scores on any licensure examination required in rule 653—9.7(147,148) that the applicant has taken in any jurisdiction. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

e. A photocopy of the applicant's medical degree issued by an educational institution.

(1) A complete translation of any diploma not written in English shall be submitted. An official transcript, written in English and received directly from the school, showing graduation from medical school is a suitable alternative.

(2) An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

(3) If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

f. A sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution.

g. An official transcript, or its equivalent, received directly from the school for every medical school attended if requested by the board. A complete translation of any transcript not written in English shall be submitted if requested by the board. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

h. If the educational institution awarding the applicant the degree has not been approved by the board, a current ECFMG status report or evidence of successful completion of a fifth pathway program in accordance with criteria established by AMA. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

i. Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)“*c.*” An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative.

j. Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

k. A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

l. A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.

m. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending. Copies of the legal documents may be requested if needed during the review process.

n. A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

653—9.5(272C) Licensure by verification. Licensure by verification is available in accordance with the following:

9.5(1) Eligibility. A person may seek licensure by verification if the person is currently licensed as a physician in at least one other jurisdiction that has a scope of practice substantially similar to that of Iowa.

9.5(2) Board application. The applicant must submit the following:

- a. A completed application for licensure by verification.
- b. A nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(1) “a.”
- c. A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.
- d. A verification form, completed by the licensing authority in the jurisdiction that issued the applicant’s license, verifying that the applicant’s license in that jurisdiction complies with the requirements of Iowa Code section 272C.12. The completed verification form must be sent directly from the licensing authority to the board.
- e. Proof of passing an examination as required by rule 653—9.7(147,148).
- f. A copy of the complete criminal record, if the applicant has a criminal history.
- g. A copy of the relevant disciplinary documents, if another jurisdiction has taken disciplinary action against the applicant.
- h. A written statement from the applicant detailing the scope of practice in the other state.
- i. Copies of relevant laws setting forth the scope of practice in the other state.

9.5(3) Applicants with prior discipline. If another jurisdiction has taken disciplinary action against an applicant, the board will determine whether the cause for the disciplinary action has been corrected and the matter has been resolved. If the board determines the disciplinary matter has not been resolved, the board will neither issue a license nor deny the application for licensure until the matter is resolved. A person who has had a license revoked, or who has voluntarily surrendered a license, in another jurisdiction is ineligible for licensure by verification.

9.5(4) Applicants with pending licensing complaints or investigations. If an applicant is currently the subject of a complaint, allegation, or investigation relating to unprofessional conduct pending before any regulating entity in another jurisdiction, the board will neither issue a license nor deny the application for licensure until the complaint, allegation, or investigation is resolved.

9.5(5) Temporary licenses. Applicants who satisfy all requirements for a license under this section except for passing a required examination specific to the laws of this state may be issued a temporary license that is valid for a period of three months and may be renewed once for an additional period of three months. The applicant must submit proof of passing the required examination before the temporary license expires.

653—9.6(147,148) Licensure examinations.

9.6(1) USMLE.

- a. The USMLE is a multipart examination consisting of Step 1, Step 2, and Step 3. Steps 1 and 2 are administered by NBME and ECFMG. The board contracts with FSMB for the administration of Step 3.
- b. Applications are available at Department of Examination Services, FSMB, 400 Fuller Wiser Road, Suite 300, Eules, Texas 76039, or www.fsmb.org.
- c. Candidates who meet the following requirements are eligible to take USMLE Step 3:
 - (1) Submit a completed application form and pay the required examination fee as specified in rule 653—8.3(147,148,272C).
 - (2) Document successful completion of USMLE Steps 1 and 2 in accordance with the requirements of NBME. Graduates of a foreign medical school shall meet the requirements of ECFMG.
 - (3) Document holding a medical degree from a board-approved educational institution. If a candidate holds a medical degree from an educational institution not approved by the board at the time

the applicant graduated and was awarded the degree, the candidate shall meet the requirements specified in subparagraph 9.3(1)“b”(3).

(4) Document successful completion of a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Step 3 or enrollment in a resident training program approved by the board at the time of the application for Step 3.

d. The following conditions apply to applicants for licensure in Iowa who utilize USMLE as the licensure examination:

(1) Passing Steps 1, 2, and 3 is required within a ten-year period beginning with the date of passing either Step 1 or Step 2, whichever occurred first. If the applicant did not pass Steps 1, 2, and 3 within the required time frame, then the requirement will be satisfied by either proof of active board certification by the ABMS or AOA or proof the delay was caused by participation in a joint M.D./Ph.D. or D.O./Ph.D. program.

(2) Step 3 may be taken and passed only after Steps 1 and 2 are passed.

(3) A score of 75 or better on each step shall constitute a passing score on that step.

(4) Successful completion of a continuous, progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Step 1 or six attempts on Step 2 CK and Step 2 CS combined or three attempts on Step 3.

9.6(2) NBME. Successful completion of NBME Parts I, II and III with a passing score of 75 or better on each part is required for NBME certification.

9.6(3) FLEX.

a. (Old) FLEX is a three-day examination administered from 1968 to 1985. Applicants who took (Old) FLEX shall provide evidence of successful achievement of at least two of the following:

(1) Certification under seal that the applicant passed FLEX with a FLEX-weighted average of 75 percent or better, as determined by the state medical licensing authority, in no more than two sittings.

(2) Verification under seal of medical licensure in the state that administered the examination.

(3) Evidence of current certification by an American specialty board approved or recognized by the Council of Medical Education of AMA, ABMS, or AOA.

b. (New) FLEX is a three-day nationally standardized examination administered from 1985 to 1994. To be eligible for licensure, the candidate must have passed both components with a FLEX score of 75 or better within a seven-year period beginning with the date of initial examination.

9.6(4) Combination examination sequences. The board approved the following licensing combinations of examinations for licensure only if completed prior to January 1, 2000. These combinations are now only acceptable from an applicant who already holds a license from any United States jurisdiction.

a. FLEX Component I plus USMLE Step 3 with a passing score of 75 or better on each examination;

b. NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component II with a passing score of 75 or better on each examination; or

c. NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3 with a passing score of 75 or better on each examination.

9.6(5) COMLEX. COMLEX is a three-level examination that replaced the three-part NBOME examination. All three examinations must be successfully completed in sequential order within ten years of the successful completion of COMLEX Level 1. If the applicant did not pass Levels 1, 2, and 3 within the required time frame, then the requirement will be satisfied by either proof of active board certification by the ABMS or AOA or proof the delay was caused by participation in a joint D.O./Ph.D. or M.D./Ph.D. program.

a. A standard score of 400 on Level 1 or Level 2 is required to pass the examination. A standard score of 350 on Level 3 is required to pass the examination.

b. A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for Level 3 or

enrollment in a resident training program approved by the board at the time of the application for Level 3.

c. Successful completion of a continuous, progressive three-year resident training program is required if the applicant passes the examination after more than six attempts on Level 1 or six attempts on Level 2 CE and Level 2 PF combined or three attempts on Level 3.

d. Each COMLEX level must be passed individually, and individual level scores shall not be averaged to compute an overall score.

e. Level 3 may be taken and passed only after Levels 1 and 2 are passed.

f. A failure of any COMLEX level, regardless of the jurisdiction for which it was taken, shall be considered a failure of that level for the purposes of Iowa licensure.

9.6(6) NBOME.

a. NBOME was a three-part examination. All three parts must have been successfully completed in sequential order within seven years of the successful completion of NBOME Part 1.

b. A passing score is required on each part of the examination.

c. A candidate shall have successfully completed a minimum of seven calendar months of resident training in a program approved by the board at the time of the application for NBOME Part 3. Candidates shall have completed their resident training by the last day of the month in which the examination was taken.

d. Successful completion of a three-year resident training program is required if the applicant passes the examination after more than six attempts on Part 1 or six attempts on Part 2 or three attempts on Part 3.

e. Each NBOME part must have been passed individually, and individual part scores shall not be averaged to compute an overall score.

f. Part 3 must have been taken and passed only after Parts 1 and 2 were passed.

g. A failure of any NBOME part, regardless of the jurisdiction for which it was taken, shall be considered a failure of that part for the purposes of Iowa licensure.

9.6(7) LMCC. The board accepts toward Iowa licensure a verification of a licensee's registration with the Medical Council of Canada, based on passing both parts of the Medical Council of Canada Qualifying Examination.

9.6(8) State licensing examinations. Licensing examinations administered by the board of medicine or another U.S. jurisdiction prior to 1974 are accepted if the examination was passed according to criteria established by that state at the time and led to licensure in that state.

653—9.7(147,148) Permanent licensure application review process. The process below is utilized to review each application. Priority is be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

9.7(1) An application for initial licensure will be considered open from the date the application form is received in the board office with the nonrefundable initial licensure fee.

9.7(2) After reviewing each application, board staff will notify the applicant about how to resolve any problems. An applicant shall provide additional information when requested by staff or the board.

9.7(3) If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

9.7(4) If the final review indicates questions or concerns that cannot be remedied by continued communication with the physician, the executive director, director of licensure and director of legal affairs will determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

a. If there is no current concern, staff will administratively grant the license.

b. If any concern exists, the application will be referred to the committee.

9.7(5) Staff will refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

9.7(6) If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant the license administratively.

9.7(7) If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee will recommend that the board:

- a.* Request an investigation;
- b.* Request that the applicant appear for an interview;
- c.* If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:
 - (1) Successfully pass a competency evaluation approved by the board;
 - (2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;
 - (3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or
 - (4) Successfully complete a reentry to practice program or monitoring program approved by the board.

- d.* Grant a license;
- e.* Grant a license under certain terms and conditions or with certain restrictions;
- f.* Request that the applicant withdraw the licensure application; or
- g.* Deny a license.

9.7(8) The board will consider applications and recommendations from the committee and will:

- a.* Request further investigation;
- b.* Require that the applicant appear for an interview;
- c.* If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada, require an applicant to:
 - (1) Successfully pass a competency evaluation approved by the board;
 - (2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;
 - (3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or
 - (4) Successfully complete a reentry to practice program or monitoring program approved by the board.

- d.* Grant a license;
- e.* Grant a license under certain terms and conditions or with certain restrictions;
- f.* Request that the applicant withdraw the licensure application; or
- g.* Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.17(147,148).

653—9.8(147,148) Licensure application cycle.

9.8(1) *Failure to submit application materials.* If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application will be considered inactive.

9.8(2) *Reactivation of the application.* To reactivate the application, an applicant shall submit a nonrefundable fee for reactivation of the application as specified in 653—paragraph 8.4(1) "b" within 30 days. If the application is not reactivated within 30 days, the application for licensure is withdrawn and the applicant must reapply and submit a new nonrefundable application fee and a new application, documents and core credentials.

9.8(3) *Period of reactivation.* The period for reactivation of application shall extend 90 days from the date the request and fee are received in the board office. During this period, the applicant

shall update core credentials and submit the remaining requested materials. If the applicant does not update core credentials or submit all materials during the 90-day period of reactivation, the application for licensure is withdrawn and the applicant must reapply and submit a new nonrefundable application fee and a new application, documents and core credentials.

653—9.9(147,148) Discretionary board actions on licensure applications. As circumstances warrant, the board may determine that any applicant for licensure is subject to the following:

9.9(1) The board may impose limits or restrictions on the practice of any applicant in this state that are equal in force to the limits or restrictions imposed on the applicant by any jurisdiction.

9.9(2) The board may defer final action on an application for licensure if there is an investigation or disciplinary action pending against an applicant in any jurisdiction until such time as the board is satisfied that licensure of the applicant poses no risk to the health and safety of Iowans.

9.9(3) The board is not precluded from taking disciplinary action after licensure is granted related to issues that arose in the licensure application process.

653—9.10(147,148) Issuance of a license.

9.10(1) *Issuance.* Upon the granting of permanent or administrative medicine licensure, staff will issue a license to practice that will expire on the first day of the licensee's birth month.

a. Licenses of persons born in even-numbered years shall expire in an even-numbered year, and licenses of persons born in odd-numbered years shall expire in an odd-numbered year.

b. The license shall not be issued for a period less than two months or greater than two years and two months, in accordance with the licensee's month and year of birth.

c. When a resident physician receives a permanent Iowa license, the resident physician license will immediately become inactive.

d. When a physician with a special license receives a permanent Iowa license, the special license will immediately become inactive.

e. When a physician with a permanent Iowa license receives an Iowa administrative medicine license, the permanent Iowa license will immediately become inactive.

f. A physician with an active permanent Iowa license is ineligible for an Iowa resident license.

9.10(2) *Display of license certificate.* The license certificate shall be displayed in the licensee's primary location of practice.

653—9.11(147,148) Notification required to change the board's data system.

9.11(1) *Change of contact information.* A licensee shall notify the board of any change in the home address, the address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board within one month of the change.

9.11(2) *Change of name.* A licensee shall notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

9.11(3) *Deceased.* A licensee file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate or other reliable information of the licensee's death.

9.11(4) *Practice name.* A licensee shall practice under the licensee's full legal name.

653—9.12(147,148) Renewal of a permanent or administrative medicine license.

9.12(1) *Licensee obligation.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

9.12(2) *Renewal application requirements.* A licensee seeking renewal shall submit a completed renewal application; information on continuing education, training on chronic pain management, training on end-of-life care, and training on identifying and reporting abuse; and the required fee prior to the expiration date on the current license.

- a. Renewal fee.*
 - (1) The fees for renewal are specified in 653—subparagraph 8.4(1)“c”(1).
 - (2) There is no renewal fee due for a physician who was on active duty in the U.S. armed forces, reserves or national guard during the renewal period.
 - (3) A physician who fails to renew before the expiration of the license is charged a penalty fee as set forth in 653—paragraph 8.4(1)“d.”
- b. The requirements for continuing education and training on identifying and reporting abuse are found in 653—Chapter 11.*

9.12(3) *Issuance of a renewal.* Upon receipt of the completed renewal application, staff will administratively issue a two-year license that expires on the first day of the licensee’s birth month. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.

9.12(4) *Failure to renew.* The license will become inactive and invalid if the licensee fails to renew a license within two months following its expiration date. A licensee whose license is invalid or inactive is prohibited from practice until the license is reactivated in accordance with rule 653—9.15(147,148).

9.12(5) *Display of license.* Renewal licenses shall be displayed along with the license certificate in the primary location of practice.

653—9.13(147,148) Inactive status of a license.

9.13(1) *Definition of inactive status.* An inactive license is any license that is not a current, active license.

- a. “Inactive status” may include licenses formerly known as delinquent, lapsed, or retired.*
- b. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reactivated to current, active status. A licensee who practices under an Iowa license when the license is inactive may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, or other available legal remedies.*

9.13(2) *Mechanisms for becoming inactive.* A licensee seeking to become inactive may submit a written request to the board office, or a license may become inactive by failing to renew a license by the first day of the third month after the expiration date.

653—9.14(147,148) Reactivation of an unrestricted Iowa license.

9.14(1) *Reactivation within one year of the license’s becoming inactive.* An individual whose license is in inactive status for up to one year and who wishes to reinstate the license shall submit a completed renewal application; the reinstatement fee; documentation of continuing education; and, if applicable, documentation on training on chronic pain management, end-of-life care, and identifying and reporting abuse. All of the information shall be received in the board office within one year of the licensee’s becoming inactive for the applicant to reinstate under this subrule.

a. Fee for reactivation of an unrestricted Iowa license within one year of the license’s becoming inactive. The reactivation fee is specified in 653—paragraph 8.4(1)“g.”

b. Continuing education and training requirements. Applicants for reactivation shall provide documentation of having completed:

- (1) The number of hours of category 1 credit needed for renewal in the most recent license period. None of the credits obtained in the inactive period may be carried over to a future license period; and
- (2) Training on chronic pain management, end-of-life care, and identifying and reporting abuse, if applicable, within the previous five years.

c. Issuance of a reactivated license. Upon receiving the completed application, staff will administratively issue a license that expires on the renewal date that would have been in effect if the licensee had renewed the license before the license expired.

d. Reinstatement application process. The applicant who fails to submit all reinstatement information required within 365 days of the license's becoming inactive shall be required to meet the reinstatement requirements of subrule 9.15(2). For example, if a physician's license expires on January 1, the completed reinstatement application is due in the board office by December 31, in order to meet the requirements of this subrule.

9.14(2) *Reactivation of an unrestricted Iowa license that has been inactive for one year or longer.* An individual whose license is in inactive status and who has not submitted a reactivation application that was received by the board within one year of the license's becoming inactive shall follow the application cycle specified in this rule and shall satisfy the following requirements for reactivation:

a. Submit an application for reactivation to the board. The application shall require the following information:

(1) Full legal name, date and place of birth, license number, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

(2) A chronology accounting for all time periods from the date of initial licensure;

(3) Every jurisdiction in which the applicant is or has been authorized to practice including license numbers and dates of issuance;

(4) Documentation of successful completion of resident training approved by the board as specified in paragraph 9.3(1)“c” that was completed since the time of initial licensure. An official FCVS Physician Information Profile that supplies this information for the applicant is a suitable alternative;

(5) Verification of the applicant's hospital and clinical staff privileges, and other professional experience for the past five years if requested by the board;

(6) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(7) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside. Copies of the legal documents may be requested if needed during the review process; and

(9) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

b. Pay the reactivation fee plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks specified in 653—paragraph 8.4(1)“f.”

c. Provide documentation of completion of 40 hours of category 1 credit within the previous two years and documentation of training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11.

d. If the physician has not engaged in active clinical practice or board-approved training in the past three years in any jurisdiction of the United States or Canada:

(1) Successfully pass a competency evaluation approved by the board;

(2) Successfully pass SPEX, COMVEX-USA, or another examination approved by the board;

(3) Successfully complete a retraining program arranged by the physician and approved in advance by the board; or

(4) Successfully complete a reentry to practice program or monitoring program approved by the board.

e. An individual who is able to submit a letter from the board with different reactivation criteria is eligible for reactivation based on those criteria.

653—9.15(147,148) Reinstatement of a restricted Iowa license. A physician whose license has been suspended or revoked following a disciplinary proceeding is required to seek reinstatement pursuant to 653—Chapter 26.

653—9.16(147,148) Relinquishment of license to practice. A person's permanent license to practice medicine and surgery, osteopathic medicine and surgery, or administrative medicine shall be deemed relinquished if the person fails to apply for renewal or reactivation of the license within five years after its expiration.

9.16(1) A license will not be reinstated, reissued, or restored once it is relinquished. The person may apply for a new license pursuant to Iowa Code sections 148.3 and 148.11 and 653—Chapters 9 and 10.

9.16(2) The relinquishment of license may be stayed if, at the date of relinquishment, there is an active:

- a.* Evaluation order pursuant to Iowa Code section 272C.9(1) and rule 653—24.4(272);
- b.* Combined statement of charges and settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.3(17A);
- c.* Statement of charges pursuant to Iowa Code section 17A.12(2) and rule 653—25.4(17A);
- d.* Settlement agreement pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and rule 653—25.17(272C);
- e.* Final decision pursuant to Iowa Code sections 17A.12 and 272C.6 and rule 653—25.24(17A); or
- f.* Application for reactivation of the license pursuant to rule 653—9.15(147,148) or 653—9.16(147,148).

653—9.17(147,148) Administrative medicine licensure.

9.17(1) *Application.* An application for an administrative medicine license shall be made to the board of medicine pursuant to the requirements established in Iowa Code section 148.3 and this chapter. An applicant for an administrative medicine license shall be subject to all of the permanent licensure requirements established in Iowa Code section 148.3 and this chapter, except that the applicant will not be required to demonstrate that the applicant has engaged in active clinical practice in the past three years as outlined in paragraphs 9.8(7) “*c*” and 9.15(2) “*d*.”

The board may issue an administrative medicine license authorizing the licensee to practice administrative medicine only, as defined by this rule. The license shall be designated “administrative medicine license.”

9.17(2) *Fees.* All license and renewal fees shall be paid to the board in accordance with 653—Chapters 8 and 9.

9.17(3) *Demonstration of competence.*

a. If an applicant for initial licensure or reactivation of an administrative medicine license has not actively practiced administrative or clinical medicine in a jurisdiction of the United States or Canada in the past three years, the board may require the applicant to demonstrate competence in a method prescribed by the board in accordance with paragraphs 9.8(7) “*c*” and 9.15(2) “*d*.”

b. A physician who holds an administrative medicine license and has not engaged in active clinical practice in a jurisdiction of the United States or Canada for more than three years may be required to demonstrate competence to practice clinical medicine in a method prescribed by the board.

9.17(4) *No exemptions to laws and rules.* A physician with an administrative medicine license is subject to the same laws and rules governing the practice of medicine as a person holding a permanent Iowa medical license.

9.17(5) *Interstate medical licensure compact.* A physician who holds only an administrative medicine license may not be eligible for licensure under the interstate medical licensure compact.

653—9.18(147,147B,148) Licensure through IMLC.

9.18(1) *Requirements for seeking a Letter of Qualification from the board of medicine.* An applicant shall meet all of the following requirements:

a. Designate Iowa as state of principal license. To designate Iowa as state of principal license, the physician must possess a full, unrestricted, permanent Iowa medical license and meet one of the following requirements at the time the application for a Letter of Qualification is reviewed by board staff:

- (1) Iowa is the physician's primary residence, or
- (2) At least 25 percent of the physician's medical practice occurs in Iowa, or
- (3) The physician's employer is located in Iowa, or
- (4) If the applicant does not meet any of the requirements under subparagraph 9.18(1) "a"(1), (2), or (3), the applicant can designate Iowa as the state of principal license if Iowa is the applicant's state of residence for the purposes of federal income tax.

b. Provide evidence of the following qualifications:

(1) Graduation from a medical school accredited by the LCME, COCA, or a medical school listed in the International Medical Education Directory or its equivalent.

(2) Passage of each component of the USMLE or the COMLEX within three attempts, or any of its predecessor examinations accepted by the board as an equivalent examination for licensure purposes as prescribed in rule 653—9.7(147,148).

(3) Successful completion of graduate medical education approved by the ACGME or the AOA. "Successful completion" means participation in an ACGME or AOA postgraduate training program that achieves ABMS or AOA board eligibility status.

(4) At the time of application, hold specialty certification or a time-unlimited specialty certificate recognized by the ABMS or the AOA. The specialty certification or a time-unlimited specialty certificate does not have to be maintained once a physician is determined to be eligible for licensure through the IMLC.

(5) Has never been convicted of or received adjudication, deferred adjudication, community supervision, or deferred disposition for any criminal offense by a court of appropriate jurisdiction.

(6) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license.

(7) Has never had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration (DEA).

(8) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

9.18(2) *Application.* A physician seeking licensure through the IMLC who is qualified to designate Iowa as state of principal license shall file an application for a Letter of Qualification with the interstate commission at www.imlcc.org and pay the nonrefundable service fee. The application shall require the following:

9.18(3) *Letter of Qualification.*

a. After evaluation of the applicant's eligibility for licensure, the Board will issue a Letter of Qualification to the applicant verifying or denying the applicant's eligibility. The applicant may appeal a determination of eligibility to the board of medicine within 30 days of issuance of the Letter of Qualification according to the processes outlined in rule 653—9.22(147,148).

b. The Letter of Qualification is valid for 365 days from its date of issuance to request licensure in a member state. The physician must maintain eligibility to claim Iowa as the state of principal license or designate a new state of principal license.

9.18(4) Expedited licensure. Physicians who have a valid Letter of Qualification may obtain licensure in Iowa through the IMLC. To obtain a permanent Iowa license through the IMLC, a qualified physician shall:

- a. Complete the application process at the IMLC's website, www.imlcc.org.
- b. Pay the licensure fee specified in 653—subrule 8.3(2) and any service fees that are required by the IMLC.
- c. Comply with the continuing medical education requirements of the board, including mandatory trainings specified in 653—Chapter 11.

9.18(5) Validity of a license issued through the IMLC. A license issued through the IMLC is valid for a period consistent with other permanent licenses issued by the board. An Iowa license issued through the IMLC shall be deemed terminated if the licensee fails to maintain a state of principal license.

9.18(6) Disciplinary actions against licenses issued through the IMLC.

a. Physicians holding an Iowa license issued through the IMLC are subject to the laws and rules governing the practice of medicine in Iowa.

b. Any disciplinary action taken by another member board of the IMLC against a physician licensed through IMLC shall be deemed unprofessional conduct that may be subject to discipline by the board in addition to any other violation of the board's rules deemed appropriate by the board.

c. If a license issued through the IMLC to a physician is revoked, surrendered, or relinquished in lieu of discipline, or suspended by a member board of the IMLC, then the physician's Iowa expedited license is automatically and immediately suspended, without further action needed, for a period of 90 days upon entry of an order by the board. The 90-day suspension may be terminated early by the board.

d. Disciplinary actions by out-of-state boards can be considered conclusive regarding legal and factual matters. The home board may impose similar or lesser sanctions, as long as the sanctions comply with the board's laws, or pursue separate disciplinary action.

e. If the Iowa board, as the physician's state of principal license, revokes or suspends the physician's license, or accepts a license surrender in lieu of discipline, then all licenses issued to the physician through the IMLC shall automatically be placed, without further action necessary by any member board, on the same status. If the Iowa board subsequently reinstates the physician's license, the licenses issued by the other member boards shall remain encumbered until the member boards take action to reinstate the licenses.

9.18(7) Renewal of license issued through the IMLC. To be eligible for renewal of a license issued through the IMLC, a licensee shall:

- a. Complete an online renewal application on a form provided by the IMLC at www.imlcc.org.
- b. Complete an attestation that the licensee:
 - (1) Maintains eligibility to designate a state as the state of principal license, pursuant to paragraph 9.21(1)“a”;
 - (2) Maintains a full and unrestricted license in the designated state of principal license;
 - (3) Has not been convicted of or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
 - (4) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;
 - (5) Has not had a controlled substance license or permit suspended or revoked by a state or the U.S. DEA.
- c. Pay licensure fee for the renewal of a license issued through the IMLC and pay any service fee assessed by the IMLC.
- d. If audited, submit verification of completion of continuing medical education requirements set forth in 653—Chapter 11.

9.18(8) Waivers. The laws and rules relating to the IMLC cannot be waived.

9.18(9) *Advisory opinions.* The board will recognize advisory opinions issued by the interstate commission on the meaning or interpretation of the IMLC, its bylaws, rules and actions when determining an applicant's eligibility for licensure through the IMLC.

653—9.19(147,148) Denial of licensure, determination of ineligibility for licensure through the IMLC, or termination of a license issued through the IMLC.

9.19(1) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

9.19(2) *Appeal procedure.* An applicant who has received a preliminary notice of licensure denial or a Letter of Qualification that asserts the board has determined that the applicant is ineligible for licensure through the IMLC, or a notice that a medical license is ineligible for renewal through the IMLC, may appeal and request a hearing on the issues related to the preliminary notice of licensure denial or ineligibility for licensure or licensure renewal through the IMLC by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the notice was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure, or a Letter of Qualification that asserts the applicant is eligible for licensure through the IMLC, or the applicant is eligible for licensure renewal through the IMLC.

9.19(3) *Hearing.* If an applicant appeals the preliminary notice of licensure denial or a determination of ineligibility for licensure or licensure renewal through the IMLC and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with rule 653—25.30(17A).

a. Hearings for applicants denied licensure, or determined to be ineligible for licensure or licensure renewal through the IMLC are contested cases open to the public.

b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.

c. Evidence supporting the denial of the license or the determination of ineligibility for licensure or licensure renewal through the IMLC may be presented by an assistant attorney general.

d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure or licensure eligibility or licensure renewal through IMLC.

e. The board, after a hearing on license denial, may grant or deny the application for licensure. The board shall state the reasons for its decision and may grant the license, grant the license with restrictions or deny the license. The final decision is a public record. After a hearing on ineligibility for licensure renewal through the IMLC, the board may uphold the termination of the license or allow the licensee to renew. The board shall state the reasons for its decision, which is a public record. After a hearing on a Letter of Qualification determination, the board may uphold the ineligible determination or issue a Letter of Qualification asserting the applicant is eligible for licensure through the IMLC. The board shall state the reasons for its decision, which is a public record.

f. Judicial review of a final order of the board denying licensure, issuing a license with restrictions, terminating a license not eligible for renewal through the IMLC, or upholding a Letter of Qualification asserting that an applicant is ineligible for licensure through the IMLC may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

9.19(4) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 9.17(2), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

9.19(5) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC, in accordance with subrule 9.17(2), but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and that the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of licensure denial or a notice of ineligibility for licensure or licensure renewal through the IMLC becomes final. A final decision under this rule is a public record.

These rules are intended to implement Iowa Code chapters 17A, 147, 147B, 148, and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 10
“Resident, Special and Temporary Physician Licensure”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147 and 148

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147 and 148

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa 50321

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed chapter sets minimum standards for entry into the medical profession with a resident, special, or temporary physician license. Iowa residents, licensees and employers benefit from the chapter since it articulates the processes by which individuals apply for these types of physician licenses in the state of Iowa, as directed in statute. This includes the processes for initial licensure, renewal, and reactivation. These requirements ensure public safety by ensuring that any individual entering the profession has minimum competency.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There is no direct cost to the general public, but there is a cost to the applicant since complying with the minimum requirements to enter into the profession is at the expense of the licensee.

The licensee would also have costs related to educational requirements and examination requirements. The Board of Medicine has not identified an exact cost of education for this field since it varies depending on the school the licensee chooses to attend to meet those requirements.

Board staff review applications for initial and renewal licenses, answer inquiries on licensing and field phone calls. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The public and professionals benefit from the proposed rules. Establishing minimum licensing requirements ensures that the residents and special licensed practitioners are competent to practice. Without having an established threshold for entry into the profession, individuals who are not appropriately trained could cause serious harm to the public during their practice. Physicians require certain skills and training to effectively help and treat their patients.

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:

Educational institutions provide the academic training for physicians to obtain their license in the state of Iowa. Additional private industries and educational institutions provide examinations and materials for preparation for the examinations. Because the cost of education is so variable depending on the institution the person attends, the Board is unable to put an exact cost on education or examination preparation.

License fees for initial resident license are \$145 and \$25 to extend if necessary. License fees for an initial special license are \$345 and \$200 for renewal.

- Qualitative description of impact:

Establishing minimum requirements for licensure ensures safety for the licensee and consumer. The cost of inaction would be increasing the potential for injury to the public by a licensee who is not qualified to perform the work in the field.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage Board activities, which include managing applications for initial licenses, renewals and reinstatements. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

- Anticipated effect on state revenues:

Costs associated with implementing this rulemaking are paid by individual licensees or establishments, not the State. This rulemaking has no anticipated impact on state revenues.

Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of resident and special licensed physicians. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

6. Alternative methods considered by the agency:

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

The Board has not identified a more cost-effective alternative to the licensure of resident and special licensed physicians. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be

reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of resident and special licensed physicians. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

Due to the state government realignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort. The Department is actively pursuing a single licensing platform to assist in standardizing licensing.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. If an individual licensee finds a rule to be overly burdensome and that the goals of which could be achieved in a manner that results in less impact on the small business, the licensee utilizes the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 10 and adopt the following **new** chapter in lieu thereof:

CHAPTER 10 RESIDENT, SPECIAL AND TEMPORARY PHYSICIAN LICENSURE

653—10.1(147,148) Definitions.

“ABMS” means the American Board of Medical Specialties.

“ACGME” means the Accreditation Council for Graduate Medical Education.

“AMA” means the American Medical Association.

“Any jurisdiction” means any state, the District of Columbia or territory of the United States of America or any other nation.

“Any United States jurisdiction” means any state, the District of Columbia or territory of the United States of America.

“AOA” means the American Osteopathic Association.

“Applicant” means a person who seeks authorization to practice medicine and surgery or osteopathic medicine and surgery in this state by making application to the board.

“Approved abuse education training program” means a training program using a curriculum approved by the abuse education review panel of the department of health and human services or a training program offered by a hospital, a professional organization for physicians, the department of health and human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“Board” means board of medicine.

“Board-approved activity” means one of the following activities:

1. Covering for an Iowa-licensed physician who unexpectedly is unavailable to provide medical care to the physician’s patients;
2. Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa;
3. Conducting a procedure on a patient in Iowa when the consultant’s expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure;
4. Providing medical care to patients in Iowa, if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program;
5. Serving as a camp physician;
6. Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction; or
7. Any other activity approved by the board.

“Board-approved resident training program” means a hospital-affiliated graduate medical education program accredited by the ACGME, AOA, RCPSC, or CFPC at the time the applicant is enrolled in the program.

“Category 1 credit” means any formal education program that is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of AOA that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“CFPC” means the College of Family Physicians of Canada.

“Committee” means the licensure committee of the board.

“ECFMG” means the Educational Commission for Foreign Medical Graduates.

“FCVS” means the Federation Credentials Verification Service.

“FSMB” means the Federation of State Medical Boards.

“Incidentally called into this state in consultation with a physician and surgeon licensed in this state” as set forth in Iowa Code section 148.2(5) means all of the following shall be true:

1. The consulting physician shall be involved in the care of patients in Iowa only at the request of an Iowa-licensed physician.
2. The consulting physician has a license in good standing in another United States jurisdiction.
3. The consulting physician provides expertise and acts in an advisory capacity to an Iowa-licensed physician. The consulting physician may examine the patient and advise an Iowa-licensed

physician as to the care that should be provided, but the consulting physician will not personally perform procedures, write orders, or prescribe for the patient.

4. The consulting physician practices in Iowa for a period not greater than 10 consecutive days and not more than 20 total days in any calendar year. Any portion of a day counts as one day.

5. The Iowa-licensed physician requesting the consultation retains the primary responsibility for the management of the patient's care.

"LCME" means Liaison Committee on Medical Education.

"Medical degree" means a degree of doctor of medicine and surgery or osteopathic medicine and surgery or comparable education from an international medical school.

"Permanent licensure" means licensure granted after review of the application and credentials to determine that the individual is qualified to enter into practice.

"Postgraduate training" means graduate medical education, e.g., an internship, residency or fellowship, in a hospital-affiliated training program approved by the board at the time the applicant was enrolled in the program.

"Practice" means the practice of medicine and surgery or osteopathic medicine and surgery.

"RCPSC" means the Royal College of Physicians and Surgeons of Canada.

"Resident physician" means a physician enrolled in an internship, residency or fellowship.

"Resident training program" means a hospital-affiliated graduate medical education program that enrolls interns, residents or fellows and may be referred to as a postgraduate training program for purposes of licensure.

"Service charge" means the amount charged for making a service available online and is in addition to the actual fee for a service itself. For example, one who renews a license online will pay the license renewal fee and a service charge.

"Training for chronic pain management" means required training on chronic pain management identified in 653—Chapter 11.

"Training for end-of-life care" means required training on end-of-life care identified in 653—Chapter 11.

"Training for identifying and reporting abuse" means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively.

"Uniform application for physician state licensure" means a web-based application that is intended to standardize and simplify the licensure application process for state medical licensure.

653—10.2(148) Licensure required. Licensure is required for practice in Iowa as identified in Iowa Code section 148.1; the exceptions are identified in 653—subrule 9.2(2).

653—10.3(147,148) Resident physician licensure.

10.3(1) General provisions.

a. The resident physician license authorizes the licensee to practice as an intern, resident or fellow while under the supervision of a licensed practitioner of medicine and surgery or osteopathic medicine and surgery in a board-approved resident training program in Iowa. When the ACGME, AOA, RCPSC, or CFPC fails to offer accreditation for a fellowship or the fellowship fails to seek accreditation, the board will approve the program if the parent program is accredited by one of the aforementioned accrediting bodies. Completion of one or more years of a program that itself lacks such accreditation does not fulfill the one-year resident training requirement for permanent licensure.

b. An Iowa resident physician license or an Iowa permanent physician license is required of any resident physician enrolled in an Iowa resident training program and practicing in Iowa.

c. A resident physician license will expire on the expected date of completion of the resident training program as indicated on the licensure application.

d. A resident physician license is valid only for practice in the program designated in the application. When the physician leaves that program, the license will immediately become inactive.

The director of the resident training program must notify the board within 30 days of the licensee's terminating from the program.

e. A resident physician licensee who changes resident training programs must apply for a new resident physician license as described in subrule 10.3(3). Such changes include a transfer to a different program in the same institution, a move to a program in another institution, or becoming a fellow after completing a residency in the same core program. An individual who contracts with an institution to be in two programs from the time of application for the resident license shall not be required to apply for another resident license for the second program.

f. A visiting resident physician may come to Iowa to practice as a part of the physician's resident training program if the physician is under the supervision of an Iowa-licensed physician. An Iowa physician license is not required of a physician in training if the physician has a resident or permanent license in good standing in the home state of the resident training program. An Iowa temporary physician license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident training program (more information can be found in rule 653—10.5(147,148)).

g. An Iowa license is not required for residents when they are training in a federal facility in Iowa. An Iowa license is not required for faculty who are teaching in and employed by a federal facility in Iowa and who are licensed in another state.

h. The director of a resident training program that enrolls a resident with an Iowa resident physician license shall report annually on October 1 on the resident's progress and whether any warnings have been issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action.

i. A resident physician licensee must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

j. A resident physician licensee's file shall be closed and labeled "deceased" when the board receives a copy of the physician's death certificate.

10.3(2) *Resident license eligibility.* To be eligible for a resident license, an applicant must meet all of the following requirements:

- a.* Fulfill the application requirements specified in subrule 10.3(3).
- b.* Be at least 20 years of age.
- c.* Hold a medical degree from an educational institution approved by the board at the time the applicant graduated and was awarded the degree.

(1) Educational institutions approved by the board must be fully accredited by an accrediting agency recognized by the board as schools of instruction in medicine and surgery or osteopathic medicine and surgery and empowered to grant academic degrees in medicine.

(2) The accrediting bodies currently recognized by the board are:

1. LCME for educational institutions granting degrees in medicine and surgery; and
2. AOA for educational institutions granting degrees in osteopathic medicine and surgery.

(3) If the applicant holds a medical degree from an educational institution not approved by the board at the time the applicant graduated and was awarded the degree, the applicant must:

1. Hold a valid certificate issued by ECFMG, or
2. Have successfully completed a fifth pathway program established in accordance with AMA criteria.

d. The applicant's license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

10.3(3) *Resident physician licensure application.*

a. Requirements. To apply for resident physician licensure, an applicant shall:

(1) Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI) as specified in 653—paragraph 8.4(2) "a"; and

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

b. Application. The application shall require the following information:

- (1) Full legal name, date and place of birth, home address, and mailing address;
- (2) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;
- (3) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;
- (4) A photocopy of the applicant's medical degree issued by an educational institution.

1. A complete translation shall be submitted for any diploma not written in English. An official transcript, written in English and received directly from the school, verifying graduation from medical school is a suitable alternative. An official FCVS Physician Information Profile is a suitable alternative.

2. If a copy of the medical degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained a medical degree from a specific educational institution;

(5) If the educational institution awarding the applicant the degree has not been approved by the board, the applicant shall provide a valid ECFMG certificate or evidence of successful completion of a fifth pathway program in accordance with criteria established by the AMA. An official FCVS Physician Information Profile is a suitable alternative;

(6) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health care facility in any jurisdiction;

(7) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(9) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.3(4) *Resident license application review process.* The process below shall be utilized to review each application for a resident license.

a. An application shall be considered open from the date the application form is received in the board office with the nonrefundable resident licensure fee.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may grant administratively a resident license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall grant administratively a resident license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, substance abuse, competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively a resident license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

- (1) Request an investigation;
- (2) Request that the applicant appear for an interview;
- (3) Grant a resident physician license for a particular residency program;
- (4) Grant a license under certain terms and conditions or with certain restrictions;
- (5) Request that the applicant withdraw the licensure application; or
- (6) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Request an investigation;
- (2) Request that the applicant appear for an interview;
- (3) Grant a resident physician license for a particular residency program;
- (4) Grant a license under certain terms and conditions or with certain restrictions;
- (5) Request that the applicant withdraw the licensure application; or
- (6) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

10.3(5) *Resident license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application shall be considered inactive. An applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

10.3(6) *Extension of a resident physician license.*

a. If the licensee fails to complete the program by the expiration date on the license, the licensee has a one-month grace period in which to complete the program or secure an extension from the board.

b. The resident physician licensee must apply for an extension if the licensee has not been granted permanent physician licensure and the licensee will not complete the program within the grace period. The following extension application materials are due in the board office prior to the expiration of the license:

- (1) A letter requesting an extension and providing an explanation of the need for an extension;
- (2) The extension fee as specified in 653—paragraph 8.4(2)“*b*”; and
- (3) A statement from the director of the resident training program attesting to the new expected date of completion of the program and the individual's progress in the program and whether any warnings have been issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action.

c. Failure of the licensee to extend a license within one month following the expiration date will cause the license to become inactive and invalid.

d. To extend an inactive resident license within one year of becoming inactive, an applicant shall submit the following:

- (1) A letter requesting an extension and providing an explanation of the need for an extension;
- (2) The extension fee as specified in 653—paragraph 8.4(2)“*b*”; and
- (3) A late fee as specified in 653—paragraph 8.4(2)“*c*”; and
- (4) A statement from the director of the resident training program attesting to the new expected date of completion of the program and the individual's progress in the program and whether any warnings have been issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action.

e. If more than one year has passed since the resident license became inactive, the applicant shall apply for a new resident license as described in subrule 10.3(3).

10.3(7) *Review process for extending a resident license.* The process below shall be utilized to review each request for an extension of a resident license.

a. An extension request shall be considered open from the date the required letters and nonrefundable extension fee are received in the board office.

b. After reviewing each request for extension, staff shall notify the licensee or designee about how to resolve any problems identified by the reviewer. The applicant for license extension shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for continued licensure, staff may grant administratively an extension to a resident license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and administration, and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall grant administratively an extension to a resident license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information in the request, criminal record, substance abuse, competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively an extension to a resident license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the licensee appear for an interview;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the licensee withdraw the request for an extension; or

(5) Deny a request for an extension of the license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the licensee appear for an interview;

(3) Grant an extension to the resident physician license;

(4) Grant an extension to the resident physician license under certain terms and conditions or with certain restrictions;

(5) Request that the licensee withdraw the request for an extension; or

(6) Deny a request for an extension of the license. The board may deny an extension of a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial of an extension is set forth in rule 653—9.15(147,148).

10.3(8) *Discipline of a resident license.* The board may discipline a license for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code section 147.55 or 148.6, Iowa Code chapter 272C, and 653—Chapter 23.

10.3(9) *Transition from a resident license to a permanent license.* When a resident physician receives a permanent Iowa license, the resident physician license shall immediately become inactive.

653—10.4(147,148) Special licensure.

10.4(1) *General provisions.*

a. The board may grant a special license to a physician who is an academic staff member of a college of medicine or osteopathic medicine if that physician does not meet the qualifications for permanent licensure but is held in high esteem for unique contributions the individual has made to medicine and will make by practicing in Iowa. The license is not designed for physicians in regular

faculty positions that could be filled by a physician qualified for permanent licensure in Iowa or for the purpose of training the physician who receives the license. The board will consider granting and renewing a special license on a case-by-case basis.

b. A special license may be issued for a period of not more than one year and may be renewed annually prior to expiration.

c. A special license will specifically limit the licensee to practice at the medical college and at any health care facility affiliated with the medical college.

d. A special license will automatically be placed on inactive status when the licensee discontinues service on the academic medical staff for which the special license was granted.

e. The board may cancel a special license if the licensee has practiced outside the scope of this license or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. When cancellation of such a license is proposed, the board shall promptly notify the licensee by sending a statement of charges and notice of hearing by certified mail to the last-known address of the licensee. This contested case proceeding shall be governed by the provisions of 653—Chapter 25.

f. A special physician licensee must notify the board of any change in home address or the address of the place of practice within one month of making an address change.

g. A special physician licensee must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

h. A special physician licensee file will be closed and labeled “deceased” when the board receives a copy of the physician’s death certificate.

i. The board may accept each 12 months of practice as a special licensee as equivalent to one year of postgraduate training in a hospital-affiliated program approved by the board for the purposes of permanent licensure.

10.4(2) *Special license eligibility.* To be eligible for a special license, an applicant shall meet all of the following requirements:

- a. Fulfill the application requirements specified in subrule 10.4(3);
- b. Be at least 21 years of age;
- c. Be a physician in a medical specialty;
- d. Present evidence of holding a medical degree from an educational institution that is located in a jurisdiction outside the United States or Canada and that is listed in the Directory of Medical Schools published by the International Medical Education Directory;
- e. Have completed at least two years of postgraduate education in any jurisdiction;
- f. Have practiced for five years after postgraduate education;
- g. Demonstrate proficiency in English by providing a valid ECFMG certificate or verification of a passing score on the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) examination administered by the Educational Testing Service;
- h. Be licensed in a jurisdiction outside the United States or Canada and present evidence that any licenses held in any jurisdiction are unrestricted; and
- i. The applicant’s license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

10.4(3) *Special license application.*

- a. *Requirements.* To apply for a special license, an applicant must:
 - (1) Pay a nonrefundable special license fee and a fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(3) “a”;
 - (2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;
 - (3) Provide verification of successful completion of a medical degree;

(4) Provide a valid ECFMG certificate or verification of a passing score on the TSE or TOEFL examination administered by the Educational Testing Service;

(5) Present a letter from the dean of the medical college in which the applicant will be practicing that indicates all of the following:

1. The applicant has been invited to serve on the academic staff of the medical school and in what capacity;

2. The applicant's qualifications and the unique contributions the applicant has made to the practice of medicine;

3. The unique contributions the applicant is expected to make by practicing in Iowa and how these contributions will serve the public interest of Iowans; and

(6) Present at least two letters of recommendation from universities, other educational institutions, or research facilities that indicate the applicant's noteworthy professional attainment.

b. Application. The application shall request the following information:

(1) Name, date and place of birth, home address, and mailing address;

(2) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(3) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(4) A photocopy of the applicant's medical degree issued by an educational institution and a sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. A complete translation of any diploma not written in English shall be submitted;

(5) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

(6) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(8) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.4(4) *Special license application review process.* The process below shall be utilized to review each application for a special license.

a. An application shall be considered open from the date the application form is received in the board office with the nonrefundable special licensure fee.

b. After reviewing each application, staff shall notify the applicant or the applicant's academic institution about how to resolve any problems identified by the reviewer. The applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant a special license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall administratively grant a special license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, substance abuse, questionable competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to grant administratively a special license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

- (1) Request that the applicant appear for an interview;
- (2) Grant a special license for practice at the medical college designated in the application;
- (3) Grant a license under certain terms and conditions or with certain restrictions;
- (4) Request that the applicant withdraw the licensure application; or
- (5) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Request that the applicant appear for an interview;
- (2) Grant a special license for practice at the medical college designated in the application;
- (3) Grant a license under certain terms and conditions or with certain restrictions;
- (4) Request that the applicant withdraw the licensure application; or
- (5) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

10.4(5) *Special license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application will be considered inactive. An applicant must reapply and submit a new nonrefundable application fee and a new application, documents and credentials.

10.4(6) *Renewal of a special license.*

a. If the special physician licensee has not qualified for and received a permanent license, the licensee must renew prior to expiration.

b. A special physician licensee may apply for a one-year renewal by submitting the following:

- (1) A completed renewal application;
- (2) The renewal fee as specified in 653—paragraph 8.4(3) “b”;
- (3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11; and
- (4) A letter from the dean of the medical college that addresses the individual's unique contribution to the practice of medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license. For a licensee who received the initial special license prior to July 1, 2001, the only statement needed from the dean is verification of the academic appointment the licensee continues to hold.

c. Failure of the licensee to renew a license within one month of the expiration date will cause the license to become inactive. A licensee whose license is inactive is prohibited from practice until a new special license is granted according to subrules 10.4(3) and 10.4(4).

653—10.5(147,148) Temporary licensure. The board may issue a temporary license authorizing a physician to participate in a board-approved activity in Iowa. Temporary licensure is granted on a case-by-case basis and depends upon the applicant's education and training, experience and licensure status elsewhere and upon the intended use of the temporary license.

10.5(1) *General provisions.*

a. The temporary license to practice is intended for a physician to participate in a board-approved activity, as defined in rule 653—10.1(147,148), in Iowa that is short-term. Temporary licensure is not intended for locum tenens.

b. The license may be restricted to the board-approved activity, location(s) or time period of up to one year.

(1) A physician who is granted a temporary license for a board-approved activity may qualify for renewal of that license if the physician needs an extension of the license for the original purpose or to pursue more than one board-approved activity within a year.

(2) A physician who wishes to continue in a board-approved activity in Iowa for short intervals beyond one year is eligible for a temporary license each year after reapplying and qualifying on an annual basis.

c. A physician incidentally called into this state in consultation with a physician and surgeon licensed in this state, as defined in rule 653—10.1(147,148), is not required to obtain a temporary license in Iowa.

d. The board may take disciplinary action on a temporary license if the licensee has practiced outside the scope of the temporary license or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. Contested case proceedings shall be governed by the provisions of 653—Chapter 25.

e. A physician who holds a temporary license must notify the board of any change in address within three days of making an address change.

f. A physician who holds a temporary license must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

g. The file of a physician who holds a temporary license will be closed and labeled “deceased” when the board receives a copy of the physician’s death certificate.

10.5(2) *Temporary license eligibility.* To be eligible for a temporary license, an applicant must meet all of the following requirements:

- a. Fulfill the requirements specified in subrules 10.5(3) and 10.5(4);
- b. Be at least 21 years of age;
- c. Hold a medical degree from an educational institution approved by the board (if the applicant is an international medical graduate, the educational institution must be listed in the International Medical Education Directory);
- d. Hold a current active, unrestricted license to practice medicine issued by any jurisdiction;
- e. Be fluent in the English language;
- f. Present a letter justifying the need for temporary licensure from the organization or individual seeking the applicant’s participation in a board-approved activity;
- g. The applicant’s license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

10.5(3) *Requirements for a temporary license.* To apply for a temporary license, an applicant must:

a. Pay a nonrefundable initial application fee and fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(4) “a.” A physician who is serving as a camp physician and who is not receiving payment other than expenses shall be exempt from the license application fee and the fee for the criminal history background check.

b. Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant.

10.5(4) *Application.* The application shall require the following information:

a. The applicant’s full legal name, date and place of birth, home address, mailing address and principal business address;

b. A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including the applicant’s license number and date of issuance of the license;

c. A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

d. A statement by the applicant that discloses and explains any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, training or research program, or health facility in any jurisdiction;

e. A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

f. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant, filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

g. A statement from the applicant that justifies the need for a temporary license, including where the applicant intends to practice and the type of practice involved;

h. A letter from the Iowa organization or individual seeking the applicant's services that explains the need for the applicant's participation in the board-approved activity in Iowa, the time period involved, the scope of practice, and the exact location and facilities where the board-approved activity will occur;

i. For an international medical graduate who does not hold a license in good standing in any United States jurisdiction, a statement, which shall be submitted by the Iowa organization or individual offering the board-approved activity, identifying who the applicant's immediate supervisor will be;

j. For an international medical graduate who does not hold a license in good standing in any United States jurisdiction:

(1) Verification, which shall be submitted from the licensing authority of the country in which the physician is licensed, that the physician has a license in good standing;

(2) Evidence of fluency in the English language;

k. For a resident physician who does not hold a current, active resident or permanent license in the home state of the resident training program, a statement, which shall be submitted by the resident director or individual offering the board-approved activity, identifying who the applicant's immediate supervisor will be; and

l. A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.5(5) *Standard application review process for a temporary license.* The standard review process shall be utilized to review each application for a temporary license, except that the process identified in subrule 10.5(6) shall be used for any international medical graduate who does not currently hold a license in good standing in any United States jurisdiction or for any physician who seeks temporary licensure for an activity not listed in paragraphs "1" through "6" of the definition of "board-approved activity" in rule 653—10.1(147,148). The standard application review process is as follows:

a. An application shall be considered open from the date the application form and the nonrefundable fees are received in the board office.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for temporary licensure or the need for a temporary licensee, staff may administratively grant a temporary license to the applicant for a specific activity, location(s) or specified duration based on the nature of the board-approved activity. The license shall not be granted for a period longer than one year.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, then the executive director, the director of licensure and administration, and the director of legal affairs shall determine if the questions or concerns indicate

any uncertainty about the applicant's current qualifications for temporary licensure or the organization's or requesting individual's need for a licensee with a temporary license.

- (1) If there is no current concern, staff shall administratively grant a temporary license.
- (2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, educational disciplinary history, or questionable need on the part of the organization.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to administratively grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

- (1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;
- (2) Grant a temporary license under certain terms and conditions or with certain restrictions;
- (3) Deny a temporary license; or
- (4) Request that the applicant withdraw the temporary licensure application.

h. The board shall consider applications and recommendations from the committee and shall:

- (1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;
- (2) Grant a temporary license under certain terms and conditions or with certain restrictions;
- (3) Request that the applicant withdraw the temporary licensure application. The request shall not imply that the applicant is ineligible for permanent licensure if that application process is pursued; or
- (4) Deny a temporary license. The board may deny a temporary license for any grounds on which the board may discipline a license or for lack of need for a physician's services by the organization or individual. The procedure for appealing a license denial is set forth in 653—9.17(147,148).

10.5(6) *Application review process for applicants with certain exceptions.* This application process shall be used to review applications submitted by an international medical graduate who does not currently hold a license in good standing in any United States jurisdiction or by a physician seeking temporary licensure for an activity not listed in paragraphs "1" through "6" of the definition of "board-approved activity" in rule 653—10.1(147,148). Following is the application review process for applicants with exceptions:

a. An application shall be considered open from the date the application form and the nonrefundable fees are received in the board office.

b. After reviewing each application, staff shall notify the applicant or designee about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for temporary licensure or the need for a temporary license, staff shall submit the application to the committee for review and recommendation to the board about whether to grant a temporary license to the physician and whether the license should be granted for a specific activity, location(s) or specified duration based on the nature of the board-approved activity.

d. The board shall consider applications and recommendations from the committee and shall:

- (1) Grant a temporary license for a specific activity, location(s) or specified duration based on the nature of the board-approved activity;
- (2) Grant a temporary license under certain terms and conditions or with certain restrictions;
- (3) Request that the applicant withdraw the temporary licensure application. The request shall not imply that the applicant is ineligible for permanent licensure if that application process is pursued; or
- (4) Deny a temporary license. The board may deny a temporary license for any grounds on which the board may discipline a license or for lack of need for a physician's services by the organization or individual. The procedure for appealing a license denial is set forth in 653—9.17(147,148).

10.5(7) *Temporary license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application will be considered inactive. An applicant whose application is inactive must reapply and submit new nonrefundable fees and a new application, documents and credentials if the applicant wishes to pursue temporary licensure.

10.5(8) *Renewal of a temporary license.*

a. To apply for renewal of a temporary license, the licensee shall submit the following:

- (1) A request for renewal;
- (2) The renewal fee as specified in 653—paragraph 8.4(4) “b”; and
- (3) Written justification for the renewal from the organization or individual seeking the applicant.

b. Failure of the licensee to renew a license by the expiration date will cause the license to become inactive. The individual shall not practice in Iowa until securing a permanent medical license or until becoming eligible for a second temporary license.

653—10.6(147,148,148J) Provisional licensure for foreign medical graduates.

10.6(1) *General provisions.*

a. The board may grant a provisional license to a foreign medical graduate who meets the qualifications provided in Iowa Code chapter 148J and these rules.

b. A provisional license may be issued for a period of not more than one year and may be renewed annually prior to expiration.

c. A provisional license will specifically limit the licensee to practice at the health care facility that provided the foreign medical graduate with the offer of employment as required by Iowa Code chapter 148J to qualify for this license.

d. The board may cancel a provisional license if the licensee has practiced outside the scope of this license, the licensee's employment is terminated with the health care facility who offered the licensee employment to qualify for the provisional license, or the licensee ceases to have an eligible immigration status for employment in the United States of America or for any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55, 148.6, and 272C.10 and 653—Chapter 23. When cancellation of such license is proposed, the board will promptly notify the licensee by serving a statement of charges and notice of hearing upon the licensee pursuant to 481—Chapter 506. This contested case proceeding shall be governed by the provisions of 481—Chapter 506.

e. A provisional licensee must notify the board of any change in the licensee's home address or the address of the place of practice within one month of making an address change.

f. A provisional licensee must notify the board of any change in name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

g. A provisional licensee file will be closed and labeled “deceased” when the board receives a copy of the physician's death certificate.

10.6(2) *Provisional license eligibility.* To be eligible for a provisional license, an applicant shall meet all of the following requirements:

- a.* Fulfill the application requirements specified in subrule 10.6(3);
- b.* Be at least 21 years of age;
- c.* Present evidence of holding a medical degree from an international medical program in good standing. This can be achieved in the following two ways:

(1) The international medical program the licensee successfully completed is approved by the ECFMG; or

(2) By presenting sufficient evidence to the board that the international medical program the applicant completed is substantially similar to the requirements of the LCME;

d. Be in good standing with and have no pending discipline before the licensing or regulatory institution in the foreign country;

e. Have practice in medicine and surgery or osteopathic medicine and surgery as a licensed physician for five years following the completion of a residency or substantially similar postgraduate medical training. The applicant can demonstrate the postgraduate medical training is substantially similar to a residency in the following two ways:

(1) The residency or postgraduate training is approved by the ACGME, AOA, RCPSC, or CFPC; or

(2) By presenting sufficient evidence to the board that the residency or postgraduate training is substantially similar to the requirements of one of the four agencies listed in subparagraph 10.6(2) “*e*”(1);

f. Demonstrate proficiency in English by providing a valid ECFMG certificate or verification of a passing score on the TSE or TOEFL examination administered by the Educational Testing Service;

g. Be licensed in a jurisdiction outside the United States or Canada and present evidence that any licenses held in any jurisdiction are unrestricted;

h. The applicant’s license is not denied by the board due to the commission of a disqualifying offense, as provided in 655—subrule 9.3(3); and

i. Have a passing score in all steps of the USMLE.

10.6(3) Provisional license application.

a. Requirements. To apply for a provisional license, an applicant must:

(1) Pay a nonrefundable special license fee and a fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and the FBI as specified in 653—paragraph 8.4(3) “*a*”;

(2) Complete and submit forms provided by the board, including required credentials, documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all the information provided by the applicant;

(3) Provide a sworn statement from the director or the director’s designee of the medical licensing or regulatory institution in the individual’s resident country that the applicant’s license is in good standing and is not subject to any pending discipline;

(4) Provide a certified record from the national policy agency in the individual’s resident country of a complete criminal history of the applicant;

(5) Provide verification of successful completion of a medical degree;

(6) Provide a valid ECFMG certificate or verification of a passing score on the TSE or TOEFL examination administered by the Educational Testing Service; and

(7) Provide a sworn statement and supporting documents from the health care facility offering employment to the provisional licensee applicant that the facility has had the applicant’s immigration status reviewed by a licensed attorney of this jurisdiction and a determination was made that the applicant has proper immigration status for employment in the United States of America.

b. Application. The application shall request the following information:

(1) Name, date and place of birth, home address, and mailing address;

(2) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance;

(3) A chronology accounting for all time periods from the date the applicant entered medical school to the date of the application;

(4) A photocopy of the applicant’s medical degree issued by an educational institution and a sworn statement from an official of the educational institution certifying the date the applicant received the medical degree and acknowledging what, if any, derogatory comments exist in the institution’s record about the applicant. A complete translation of any diploma not written in English shall be submitted;

(5) A statement disclosing and explaining any warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, educational institution, training or research program, or health facility in any jurisdiction;

(6) A statement disclosing and explaining the applicant's involvement in civil litigation related to practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process;

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; and

(8) A completed fingerprint packet to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

10.6(4) *Provisional license application review process.* The process below shall be utilized to review each application for a provisional license.

a. An application is considered open from the date the application form is received in the board office with the nonrefundable provisional licensure fee.

b. After reviewing each application, staff will notify the applicant or the health care facility offering the applicant employment about how to resolve any problems identified by the reviewer. The applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant a provisional license.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, director of licensure and administration, and director of legal affairs will determine whether the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff will administratively grant a provisional license.

(2) If any concern exists, the application will be referred to the committee.

e. Staff will refer to the committee for review matters that include but are not limited to falsification of information on the application, criminal record, substance abuse, questionable competency, physical or mental illness, or educational disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to administratively grant a provisional license.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee will recommend that the board:

(1) Request that the applicant appear for an interview;

(2) Grant a provisional license;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the applicant withdraw the licensure application; or

(5) Deny a license.

h. The board will consider applications and recommendations from the committee and:

(1) Request that the applicant appear for an interview;

(2) Grant a provisional license for practice at the medical college designated in the application;

(3) Grant a license under certain terms and conditions or with certain restrictions;

(4) Request that the applicant withdraw the licensure application; or

(5) Deny a license. The board may deny a license for any grounds on which the board may discipline a license. The procedure for appealing a license denial is set forth in rule 653—9.15(147,148).

10.6(5) *Provisional license application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application will be considered inactive. An applicant must reapply and submit a new nonrefundable application fee and a new application, new documents and new credentials.

10.6(6) *Renewal of a provisional license.*

a. If the provisional licensee has not qualified for and received a permanent license, the licensee must renew prior to expiration.

- b.* A provisional licensee may apply for a one-year renewal by submitting the following:
- (1) A completed renewal application;
 - (2) The renewal fee as specified in 653—paragraph 8.4(3) “*b*”;
 - (3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11; and
 - (4) A letter from the chief medical officer for the health care facility employing the licensee that addresses the individual’s fitness to the practice of medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license.
- c.* Failure of the licensee to renew a license within one month of the expiration date will cause the license to become inactive. A licensee whose license is inactive is prohibited from practice until a new provisional license is granted according to subrules 10.4(3) and 10.4(4).

10.6(7) *Conversion of a provisional license to a full license.*

a. After three consecutive years of holding a provisional license in good standing, the provisional licensee may apply to have the licensee’s license converted to a full license to practice medicine and surgery or osteopathic medicine and surgery, provided the license has not been revoked pursuant to Iowa Code section 148J.2. The provisional licensee may alternatively elect to continue to renew the licensee’s provisional license on a yearly basis.

b. The provisional licensee shall make application to the board for conversion of the licensee’s provisional license using the application form provided by the board. The application shall include the following:

- (1) A completed application;
- (2) The renewal fee as specified in 653—paragraph 8.4(3) “*b*”;
- (3) Evidence of continuing education and training on chronic pain management, end-of-life care, and identifying and reporting abuse as specified in 653—Chapter 11.
- (4) A letter, submitted by the chief medical officer for the health care facility employing the licensee, that addresses the individual’s fitness to practice medicine in Iowa, how the anticipated contribution will serve the public interest of Iowans, and the need for renewal of this license.
- (5) An updated criminal background check as described in subrule 10.6(3).
- (6) A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.
- (7) A statement disclosing and explaining the applicant’s involvement in civil litigation related to the practice in any jurisdiction. Copies of the legal documents may be requested if needed during the review process.
- (8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding to have the conviction or plea set aside is pending. Copies of the legal documents may be requested if needed during the review process.
- (9) The full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.
- (10) A statement listing every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

These rules are intended to implement Iowa Code chapters 17A, 147, 148, 148J, and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 11
“Continuing Education and Training Requirements”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 272C

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed chapter sets forth continuing education requirements for physicians, acupuncturists, and genetic counselors. It includes definitions related to continuing education, the number of hours of continuing education that licensees are required to obtain, the standards that licensees need to meet in order to comply with the chapter, and the types of continuing education courses that are permissible. The intended benefit of continuing education is to ensure that licensees maintain up-to-date practice standards and, as a result, provide high-quality services to Iowans.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:

There are no direct costs to the public. There is a direct cost to the licensee, who must pay for the continuing education required. Private industry offers these courses, so the Board of Medicine is not privy to exact costs, but they can vary from no cost to several thousand dollars. However, most continuing education offerings are between \$50 and \$200. There are multiple entities that provide continuing education courses to licensees. Often, hospital and clinical groups will offer these to their physicians free of charge.

Costs to the agency are for the staff time needed to manage Board activities, which include continuing education. The time needed to manage this provision is generally in the form of responding to questions related to continuing education requirements. An executive officer supports the full scope

of work of this Board at approximately 0.31 full-time equivalent (FTE) position, which includes answering questions from the public and licensees on topics such as practice standards, continuing education, and Board meeting administration. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes the benefit is being achieved because the chapter requires that licensees meet specific continuing education requirements and continually update their knowledge base regarding their practice. This ensures that licensees understand best practices in an evolving field, which allows them to provide the best care to Iowans and potentially reduces the number of complaints. While there is no evidence to prove this correlation, this has been a long-standing belief that boards around the country have held, as is evidenced by the fact that most other boards around the country require some form of continuing education.

Most states have the same requirement as Iowa (40 hours of continuing education every two years). There are a number of states that require more hours. There are three states that require fewer: Vermont, Wisconsin, and Oklahoma. Notably, South Dakota does not require any continuing education. Requirements can be found at www.fsmb.org/siteassets/advocacy/regulatory/licensure/continuing-medical-education-requirements.pdf.

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:

Private industry offers these courses, so the Board is not privy to exact costs, but they can vary from no cost to several thousand dollars. However, most continuing education offerings are between \$50 and \$200. There are multiple entities that provide continuing education courses to licensees. Often, hospital and clinical groups will offer these to their physicians free of charge.

The Board believes that eliminating continuing education requirements may increase the number of complaints and investigations that the Board would need to conduct, but the Board has not been able to analyze this correlation so is unable to submit evidence of this belief.

- Qualitative description of impact:

There has been a historical belief that continuing education has a public safety benefit because it ensures the licensed professionals are receiving education on up-to-date standards of care and potentially reduces the number of complaints. While there is no evidence to prove this correlation, this has been a long-standing belief that boards around the country have held, as is evidenced by the fact that most other boards around the country require some form of continuing education.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage Board activities, which include continuing education. The time needed to manage this provision is generally in the form of responding to questions related to continuing education requirements. An executive officer supports the full scope of work of this Board at approximately 0.31 FTE position, which includes answering questions from the public and licensees on topics such as practice standards, continuing education, and Board meeting administration. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

- Anticipated effect on state revenues:

Costs associated with implementing this chapter are paid by individual licensees or establishments, not the State. This rulemaking has no anticipated impact on state revenues.

Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes that the costs are justified by the benefits achieved. The purpose of continuing education is to ensure ongoing competency for providers. The Board believes that eliminating continuing education requirements may increase the number of complaints and investigations that the Board would need to conduct, but the Board has not been able to analyze this correlation so is unable to submit evidence of this belief.

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

As explained above, South Dakota does not require any continuing education. However, without continuing education, there is question as to whether licensees would achieve the desired benefit of an updated practice knowledge and increased safety for Iowans. The Board believes continuing education is necessary and that the number of hours currently required ensures public safety and competent practice by physicians in Iowa.

6. Alternative methods considered by the agency:

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

The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Continuing education hours could be reduced or eliminated. However, without continuing education, there is question as to whether licensees would achieve the desired benefit of updated practice knowledge and increased safety for Iowans. The Board believes continuing education is necessary and that the number of hours currently required ensures public safety and competent practice by physicians in Iowa.

The proposed rules do allow for carryover of up to 50 percent of a licensee's continuing education hours if the licensee has more continuing education hours than required for the reporting period pursuant to updates from the 2024 Legislative Session.

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

Without continuing education, there is question as to whether licensees would achieve the desired benefit of updated practice knowledge and increased safety for Iowans. The Board believes continuing education is necessary and that the number of hours currently required ensures public safety and competent practice by physicians in Iowa.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt a small business from adhering to this chapter would jeopardize any member of the public who sought

services from that small business. The risk to the public is greater than the potential harm or cost to the small business. If the individual licensee finds a rule to be overly burdensome and the goals of which could be achieved in a manner that results in less impact on the small business, the licensee utilizes the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 11 and adopt the following **new** chapter in lieu thereof:

CHAPTER 11
CONTINUING EDUCATION AND TRAINING REQUIREMENTS

653—11.1(272C) Definitions.

“*ABMS*” means the American Board of Medical Specialties. The board recognizes specialty board certification by ABMS.

“*Accredited provider*” means an organization approved as a provider of category 1 credit by one of the following board-approved accrediting bodies: Accreditation Council for Continuing Medical Education, Iowa Medical Society, or the Council on Continuing Medical Education of the AOA.

“*Active duty*” means full-time training or active service in the U.S. armed forces, reserves or national guard.

“*Active licensee*” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in Iowa who has met all conditions of licensure and maintains a current license to practice in Iowa.

“*AMA*” means the American Medical Association.

“*AOA*” means the American Osteopathic Association.

“*Approved abuse education training program*” means a training program using a curriculum approved by the abuse education review panel of the department of health and human services or a training program offered by a hospital, a professional organization for physicians, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“*Approved program or credit*” means any category 1 credit offered by an accredited provider or any other program or credit meeting the standards set forth in these rules.

“*Board*” means the board of medicine.

“*Carryover*” means hours of category 1 credit earned in excess of the required hours in a license period that may be applied to the continuing education requirement in the subsequent license period; carryover may not exceed 20 hours of category 1 credit per renewal cycle.

“*Category 1 credit*” means any formal education program that is sponsored by an accredited provider. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“*Committee*” means the licensure committee of the board.

“*COMVEX-USA*” means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America.

“*Continuing education*” means education that is acquired by a licensee in order to maintain or enhance skills and knowledge present at initial licensure or to develop relevant skills and knowledge.

“*Hour of continuing education*” means a clock hour spent by a licensee in actual attendance at or completion of an approved category 1 credit.

“*Inactive license*” means any license that is not a current, active license.

“*Licensee*” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa.

“*Opioid*” means any FDA-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“*Service charge*” means the amount charged for making a service available on line and is in addition to the actual fee for a service itself.

“*SPEX*” means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction. The passing score on SPEX is 75.

“*Training for identifying and reporting abuse*” means training as described in Iowa Code section 232.69; the full requirements for reporting of dependent adult abuse and the training requirements are in Iowa Code section 235B.16.

653—11.2(272C) Continuing education credit and alternatives.

11.2(1) Continuing education credit may be obtained by attending category 1 credits as defined in this chapter.

11.2(2) The board accepts the following as equivalent to 50 hours of category 1 credit: participation in an approved resident training program or board certification or recertification by an ABMS or AOA specialty board within the licensing period.

11.2(3) Each year, the board acknowledges up to ten hours of category 1 credits for physicians who served on the board or Iowa professional health committee, are actively serving alternate members, or performed peer reviews in the previous year. Recipients are notified by the board’s executive director via mail in January.

653—11.3(272C) Continuing education and training requirements for renewal or reactivation. A licensee shall meet the requirements in this rule to qualify for renewal of a permanent license, an administrative medicine license, or special license or to qualify for reactivation of a permanent license or an administrative medicine license.

11.3(1) *Continuing education and training requirements.*

a. Continuing education for permanent license or administrative medicine license renewal. Except as provided in these rules, a total of 40 hours of category 1 credit or board-approved equivalent is required for biennial renewal of a permanent license or an administrative medicine license. This may include up to 20 hours of carryover credit.

(1) To facilitate license renewal according to birth month, a licensee’s first license may be issued for less than 24 months. The number of hours of category 1 credit required of a licensee whose license has been issued for less than 24 months shall be reduced on a pro-rata basis.

(2) A licensee desiring to obtain credit for carryover hours reports the carryover, not to exceed 20 hours of category 1 credit, on the renewal application.

b. Continuing education for special license renewal. A total of 20 hours of category 1 credit shall be required for annual renewal of a special license. No carryover hours are allowed.

c. Training for identifying and reporting child and dependent adult abuse for permanent or special license renewal. A licensee shall complete the training for identifying and reporting child and dependent adult abuse as part of a category 1 credit or an approved training program. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.3(1) “a.”

(1) Training to identify child abuse. A licensee who regularly provides primary health care to children in Iowa must complete at least two hours of training provided by the department of health and human services pursuant to Iowa Code section 232.69(3) “c” in child abuse identification and reporting every three years. “A licensee who regularly provides primary health care to children” means all emergency physicians, family physicians, general practice physicians, pediatricians, and psychiatrists, and any other physician who regularly provides primary health care to children.

(2) Training to identify dependent adult abuse. A licensee who regularly provides primary health care to adults in Iowa must complete at least two hours of training provided by the department of health and human services pursuant to Iowa Code section 235B.16(5)“c” in dependent adult abuse identification and reporting every three years. “A licensee who regularly provides primary health care to adults” means all emergency physicians, family physicians, general practice physicians, internists, obstetricians, gynecologists, and psychiatrists and any other physician who regularly provides primary health care to adults.

d. Training for chronic pain management for permanent or special license renewal. The licensee shall complete the training for chronic pain management as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.3(1)“a.”

(1) Licensees who prescribed opioids in the prior license period must complete two hours of category 1 credit on U.S Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing every five years. The licensee may opt out of this requirement during license renewal if the licensee did not prescribe opioids in the previous cycle.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the chronic pain management training and shall then complete the training once every five years thereafter.

e. Training for end-of-life care for permanent or special license renewal. The licensee shall complete the training for end-of-life care as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.3(1)“a.”

(1) A licensee who regularly provides direct patient care to actively dying patients in Iowa must complete at least two hours of category 1 credit for end-of-life care every five years.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the end-of-life care training and shall then complete the training once every five years thereafter.

11.3(2) Exemptions from renewal requirements.

a. A licensee shall be exempt from the continuing education requirements in subrule 11.3(1) when, upon license renewal, the licensee provides evidence for:

(1) Periods that the licensee served honorably on active duty in the U.S. armed forces, reserves or national guard;

(2) Periods that the licensee practiced in another state or district and did not provide medical care, including telemedicine services, to patients located in Iowa if the other state or district had continuing education requirements for the profession and the licensee met all requirements of that state or district for practice therein;

(3) Periods that the licensee was a government employee working in the licensee’s specialty and assigned to duty outside the United States; or

(4) Other periods of active practice and absence from the state approved by the board.

b. The requirements for training on chronic pain management and end-of-life care for license renewal shall be suspended for a licensee who provides evidence for:

(1) Periods described in subparagraph 11.3(2)“a”(1), (2), (3), or (4); or

(2) Periods that the licensee resided outside of Iowa and did not practice in Iowa.

11.3(3) Extension for completion of or exemption from renewal requirements. The board may grant an extension of time for or an exemption from completion of the renewal requirements in subrule 11.3(1) in cases of physical disability or illness.

a. A licensee requesting an extension or exemption shall complete and submit a request to the board that sets forth the reasons for the request and has been signed by the licensee and attending physician.

b. The board may grant an extension of time to fulfill the requirements in subrule 11.3(1).

c. The board may grant an exemption from the educational requirements for any period of time not to exceed one calendar year.

d. If the physical disability or illness for which an extension or exemption was granted continues beyond the period of waiver, the licensee must reapply for a continuance of the extension or exemption.

e. The board may, as a condition of any extension or exemption granted, require the applicant to make up a portion of the continuing education requirement by methods it prescribes.

11.3(4) *Reactivation requirement.* An applicant for license reactivation whose license has been inactive for one year or more shall provide proof of successful completion of 40 hours of category 1 credit completed within 24 months prior to submission of the application for reactivation or proof of successful completion of SPEX or COMVEX-USA within one year immediately prior to the submission of the application for reinstatement.

11.3(5) *Cost of continuing education and training for renewal or reinstatement.* Each licensee is responsible for all costs of continuing education and training required in 653—Chapter 11.

11.3(6) *Documentation.* A licensee shall maintain documentation of the continuing education and training, including dates, subjects, duration of programs, and proof of participation.

11.3(7) *Audits.* The board may audit continuing education and training documentation at any time. A licensee shall respond to a board audit and provide all materials requested within 30 days of a request made by board staff.

11.3(8) *Grounds for discipline.* A licensee may be subject to disciplinary action for failure to comply with continuing education and training requirements in 653—Chapter 11.

653—11.4(272C) Failure to fulfill requirements for continuing education and training for identifying and reporting abuse.

11.4(1) Disagreement over whether material submitted fulfills the requirements specified in rule 653—11.3(272C).

a. Staff will work with a licensee or applicant to resolve any discrepancy concerning credit for renewal or reinstatement.

b. When resolution is not possible, staff will refer the matter to the committee.

(1) In the matter of a licensee seeking license renewal, staff will renew the license if all other matters are in order and inform the licensee that the matter is being referred to the committee.

(2) In the matter of an applicant seeking reactivation, staff will reactivate the license if all other matters are in order and inform the applicant that the matter is being referred to the committee.

c. The committee considers the staff's recommendation for denial of credit for continuing education or training for identifying and reporting abuse, chronic pain management, and end-of-life care.

(1) If the committee approves the credit, it will authorize the staff to inform the licensee or applicant that the matter is resolved.

(2) If the committee disapproves the credit, it will refer the matter to the board with a recommendation for resolution.

d. The board will consider the committee's recommendations.

(1) If the board approves the credit, it will authorize the staff to notify the licensee or applicant for reinstatement if all other matters are in order.

(2) If the board denies the credit, it will:

1. Close the case;

2. Send the licensee or applicant an informal, nonpublic letter of warning or education; or

3. File a statement of charges for noncompliance with the board's rules on continuing education or training and for any other violations that may exist.

11.4(2) Informal appearance for failure to complete requirements for continuing education or training.

- a.* The licensee or applicant may, within ten days after the date that the notification of the denial was sent by certified mail, request an informal appearance before the board.
- b.* At the informal appearance, the licensee or applicant will have the opportunity to present information, and the board will issue a written decision.

These rules are intended to implement Iowa Code chapters 147 and 272C and sections 232.69 and 235B.16.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 13
“Standards of Practice and Principles of Medical Ethics”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 124, 124E, 135, 135L, 144E, 146A, 146E, 147, 148, 272C and 280

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 124, 124E, 135, 135L, 144E, 146A, 146E, 147, 148, 272C and 280

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa
Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking provides Iowans, licensees, and employers with the standards of practice and medical ethics. The rules give definitions relevant to the practice of medicine and guidelines on office practices, including the requirements for recordkeeping, physician behavior, and patient-physician relationships. The Board of Medicine added provisions for emergency medical services within the physician’s scope of practice pursuant to 2024 Iowa Acts, House File 2507.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:

There are costs associated with practice standards since there is often time, effort, and money associated with compliance. However, the costs generally impact the practitioner. These costs may be passed on to the consumer. The Board does not have a mechanism for estimating what these total costs might be to the public and to the licensee.

Costs to the agency are for the staff time needed to manage the full scope of Board activities, which include oversight of practice standards, answering questions from licensees and the public, administration of board meetings, etc. An executive officer and executive director support the work of this Board at approximately 0.5 full-time equivalent (FTE) position. Staff salaries are covered by the

Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees are paid into the fund to cover the costs of the Board's operations.

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

The public and the members of the profession benefit from this rulemaking. The costs are justified by the benefits achieved because the rules provide required guardrails for providing this important service to Iowans. If this profession was not regulated, it could mean that lower-skilled individuals would provide this service to Iowans, which would be of concern to the Board. Medicine is regulated in all 50 states.

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:

There are approximately 17,000 licensed individuals who provide these services to Iowans. There is a relatively large number of complaints submitted to this Board. In 2022, there were approximately 660 complaints filed with this Board, with less than 5 percent resulting in public discipline.

There are costs associated with practice standards since there is often time, effort and money associated with compliance. However, the costs generally impact the practitioner. These costs may be passed onto the consumer. The Board does not have a mechanism for estimating what these total costs might be to the public and to the licensee.

Costs to the agency are for the staff time needed to manage the full scope of Board activities, which include oversight of practice standards, answering questions from licensees and the public, administration of Board meetings, etc. An executive officer and executive director support the work of this board at approximately 0.5 FTE position. Staff salaries are covered by the fund.

- Qualitative description of impact:

The Board believes that the costs are justified by the benefits achieved because the rules provide required guardrails for providing this important service to Iowans. Without regulation, the Board has concerns about individuals without proper skills providing service to Iowans. This could cause harm to the public.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage the full scope of Board activities, which include oversight of practice standards, answering questions from licensees and the public, administration of Board meetings, etc. An executive officer and executive director support the work of this Board at approximately 0.5 FTE position. Staff salaries are covered by the fund.

- Anticipated effect on state revenues:

This rulemaking has no anticipated impact on state revenues. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

There are approximately 17,000 licensed individuals who provide these services to Iowans. There is a relatively large number of complaints submitted to this Board. In 2022, there were approximately 660 complaints filed with his board, with less than 5 percent resulting in public discipline. The Board believes that the costs are justified by the benefits achieved because the rules provide required guardrails for providing this important service to Iowans. If this profession was not regulated, it could mean that lower-skilled individuals would provide this service to Iowans, which would be of concern to the Board. Medicine is regulated in all 50 states.

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

The Board could be advisory, and registration could be used as opposed to licensing, which is the highest form of regulation. However, the intended benefit of safe medical practice in Iowa may not be met since the Board would not have the authority to carry out discipline against licensees to ensure the minimum safety standards of the profession are being met. There would be additional issues with workforce since the state may no longer qualify for the Interstate Medical Licensure Compact with physicians who are no longer licensed.

6. Alternative methods considered by the agency:

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

The Board could be an advisory body instead of a regulatory body. Registration could also be used as opposed to licensing, which is the highest form of regulation. However, the intended benefit of safe medical practice in Iowa may not be met since the Board would not have the authority to carry out discipline against licensees to ensure that the minimum safety standards of the profession are being met. There would be additional issues with the workforce since the state may no longer qualify for the Compact if it were not licensing physicians.

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

The intended benefit of a safe medical practice in Iowa may not be met since the Board would not have the authority to carry out discipline against licensees to ensure that the minimum safety standards of the profession are being met. There would be additional issues with workforce since the state may no longer qualify for the Compact if it were not licensing physicians.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large corporation. The chapter is meant to ensure public safety in terms of practice standards for physicians. While some licensees could be running a small business, some also work for large hospitals and clinics. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 13 and adopt the following **new** chapter in lieu thereof:

CHAPTER 13
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

13.1(1) A physician shall dispense a prescription drug only in a container that meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. Sections 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. Section 301 et seq. (2001).

13.1(2) A label affixed to a container in which a prescription drug is dispensed by a physician shall include:

- a. The name and address of the physician.
- b. The name of the patient.
- c. The date dispensed.
- d. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
- e. The name and strength of the prescription drug in the container.

13.1(3) The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

13.1(4) Physicians must document all prescription drugs dispensed to patients, including required label information. Noting such information on the patient's chart or record maintained by the physician is sufficient.

653—13.2(124,148,272C) Standards of practice—appropriate pain management.

13.2(1) *Standards.* This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of nonopioid pharmacologic therapy and nonpharmacologic therapy.

a. This rule is intended to encourage appropriate pain management, including the use of opioids for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

b. The goal of pain management is to treat each patient's pain in relation to the patient's overall health. At the end of life, the goals may shift to palliative care.

c. Pain management is an important part of medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

d. Physicians treating pain with opioids in a manner consistent with appropriate pain management practices should not fear board action. Dosage is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

e. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(2) *Definitions.* For the purposes of this rule, the following terms are defined as follows:

"*Acute pain*" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

"*Addiction*" means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"*Chronic pain*" means pain that lasts longer than three months or past the time of normal tissue healing.

“Pain” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

“Physical dependence” means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

“Pseudoaddiction” means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

“Substance abuse” means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

“Tolerance” means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

“Undertreatment of pain” means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(3) *Laws and regulations.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations.

13.2(4) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use opioids for terminal pain due to the physician’s concern with addicting the patient, or a failure to use an adequate level of pain management.

13.2(5) *Assessment and treatment of acute and chronic pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute and chronic pain.

a. Prescribing opioids for the treatment of acute and chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented pain. Appropriate management of acute and chronic pain should include an assessment of the mechanism, type and intensity of pain. The patient’s medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

b. A physician who prescribes, dispenses or administers opioids to patients for the treatment of chronic pain should become familiar with the U.S. Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain published on March 15, 2016.

13.2(6) *Effective management of chronic pain.* To ensure that chronic pain is properly assessed and treated, a physician who prescribes, dispenses or administers opioids to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. Prior to the patient starting treatment, a patient evaluation must be conducted that includes a physical examination, a comprehensive medical history, pain assessment, and examination of physical and psychological function. This evaluation should also cover diagnostic studies, past interventions, medication and substance abuse history, and any underlying conditions. Depending on the complexity of the case and the physician’s expertise, consultation or referral to specialists in pain medicine, addiction medicine, or areas associated with the patient’s pain may be necessary. Interdisciplinary evaluation is recommended.

b. Treatment plan. The physician must create a tailored treatment plan addressing the patient’s individual needs, outlining treatment objectives such as pain relief or improved functioning, and

indicating any planned diagnostic evaluations or treatments. The plan should include other treatment modalities and rehabilitation programs used. Short- and long-term pain relief needs should be considered, along with the patient's ability to request pain relief and the patient's setting. Whenever possible, opioids should be prescribed by one physician and filled at one pharmacy.

c. *Informed consent.* A discussion of the risks and benefits of opioids with the patient or person representing the patient must be documented.

d. *Periodic review.* The physician must regularly review the patient's drug treatment course and pain source. Drug therapy should be adjusted to meet individual patient needs, based on progress toward treatment plan objectives. If reviews show treatment plan objectives are not being met or indicate diversion or substance abuse patterns, the physician should reconsider drug therapy and explore other treatment options. Long-term opioid use may lead to tolerance and abnormal pain sensitivity, meaning increasing doses may not improve pain control or function.

e. *Consultation/referral.* A specialty consultation, including with a physician with expertise in addiction medicine or substance abuse counseling, may be considered if there is evidence of significant adverse effects, lack of response to the medication, diversion, or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management.

f. *Documentation.* The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. *Pain management agreements.* Physicians treating chronic pain with opioids should consider implementing a pain management agreement with each patient outlining medication use rules and consequences for misuse. The decision to use such an agreement should be based on individual patient evaluation, weighing risks and benefits of long-term opioid treatment. If opioid treatment exceeds 90 days for chronic pain, and there is a concern for drug abuse or diversion, a pain management agreement should be used. If a physician opts not to use a pain management agreement, reasons should be documented in the patient's medical records. Pain management agreements are not required for hospice or nursing home patients.

h. *Substance abuse history or comorbid psychiatric disorder.* A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. *Drug testing.* A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain should consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. *Termination of care.* The physician should consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

13.2(7) *Pain management for terminal illness.* The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opioids to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(8) *Prescription monitoring program.* The board of pharmacy established a prescription monitoring program pursuant to Iowa Code sections 124.551 through 124.558 to help prescribers and

pharmacists track controlled substance prescriptions. Physicians must register for this program when applying for or renewing their controlled substance prescribing registration. Before prescribing opioids, physicians or their agents must use the program to guide treatment decisions and enhance patient care quality. However, utilization is not required for patients in inpatient hospice care or long-term residential facilities. Orders in hospital settings are not considered prescriptions under these rules, as patient safety is managed within these settings.

13.2(9) *Electronic prescriptions.* Beginning January 1, 2020, all prescriptions (controlled and noncontrolled substances) are to be transmitted electronically as electronic prescriptions pursuant to Iowa Code section 124.308. A prescription shall be transmitted to a pharmacy by the physician or the physician's authorized agent in compliance with federal law and regulation for electronic prescriptions of controlled substances.

13.2(10) *Pain management resources.* The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group in collaboration with an expert advisory panel, actively practicing providers and public stakeholders, the guideline focuses on evidence-based treatment for chronic-pain patients. The guideline was published in 2007 and updated in 2015.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB's) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

h. CDC Guideline for Prescribing Opioids for Chronic Pain as referenced in paragraph 13.2(4) "b."

13.2(11) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules, the rules found in 653—Chapter 23, or any of the following:

a. A physician who prescribes opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent physician in the state of Iowa acting in the same or similar circumstances.

b. A physician who knowingly fails to comply with the confidentiality requirements of Iowa Code section 124.553 or who delegates program information access to another individual except as provided in Iowa Code section 124.553.

c. A physician who knowingly fails to comply with other requirements of Iowa Code chapter 124.

13.2(12) *Unlawful access, disclosure, or use of information.* A person who intentionally or knowingly accesses, uses, or discloses information from the prescription monitoring program in violation of Iowa Code section 124.553, unless otherwise authorized by law, is guilty of a class “D” felony. This subrule shall not preclude a physician who requests and receives information from the prescription monitoring program consistent with the requirements of Iowa Code section 124.553 from otherwise lawfully providing that information to any other person for medical care purposes.

653—13.3(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

653—13.4(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician must be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

13.4(1) An internal quality control assurance plan shall include the following elements:

- a. The name of the physician responsible for the plan and testing;
- b. Methods that the dispensing system employs to ensure the accuracy of the patient’s name and medication, dosage, directions and amount of medication prescribed;
- c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;
- d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;
- e. Staff training and qualifications for dispensing via the dispensing system;
- f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;
- g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;
- h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;
- i. A plan for interval testing of the accuracy of dispensing, at least annually; and
- j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

13.4(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

13.4(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.

653—13.5(147,148,272C) Standards of practice—office practices.

13.5(1) *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician must provide a patient written notice of the termination of the physician-patient relationship. A

physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.5(2) *Patient referrals.* A physician shall not pay or receive compensation for patient referrals.

13.5(3) *Confidentiality.* A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.5(4) *Sexual conduct.* It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct that violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor or under a guardianship.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor or under guardianship, regardless of whether the patient consents to that conduct.

13.5(5) *Disruptive behavior.* A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

13.5(6) *Sexual harassment.* A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature that interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

13.5(7) *Transfer of medical records.* A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

13.5(8) *Retention of medical records.*

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Beginning July 1, 2023, a physician must appoint another Iowa-licensed physician, or other representative or entity that is held to the same standards of confidentiality as the physician, to ensure that all requirements of this subrule are met in the event of the physician's death or incapacitation. Upon request by the board, the physician must be able to establish by sufficient proof the appointment of a representative pursuant to this paragraph.

d. Upon a physician's death or retirement, the sale of a medical practice, or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician or the physician's representative shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

653—13.6(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians. This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa. This rule does not apply to the standards of practice for a nonphysician licensed health professional who serves as a medical director at a medical spa pursuant to the rules of the professional's licensing authority.

13.6(1) Definitions. As used in this rule:

"Alter" means to change the cellular structure of living tissue.

"Capable of" means any means, method, device or instrument that, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

"Damage" means to cause a harmful change in the cellular structure of living tissue.

"Delegate" means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians.

"Medical aesthetic service" means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; collagen induction therapy (microneedling); fat-freezing treatment (cool sculpting); botox injections; collagen injections; and tattoo removal.

"Medical director" means a physician who assumes the role of, or holds oneself out as, medical director at a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa. The medical director is ultimately responsible for all medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa.

"Medical spa" means any entity, however organized, that is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice that is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

"Nonsuperficial" means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

"Qualified laser technician" means any person, licensed or unlicensed, who has successfully completed a minimum of 120 hours of training, including a minimum of 40 hours of didactic study and 80 hours of clinical training, in the safe and effective use of lasers in the performance of medical aesthetic services at an accredited laser training program. For the purposes of this rule, a qualified laser technician may only use lasers in the performance of delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa. An unlicensed qualified laser technician may not perform any other medical aesthetic services defined in this rule.

“Qualified licensed or certified nonphysician person” means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another health- or skin care-related licensing board in Iowa and is qualified to perform delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa.

“Supervision” means the oversight of qualified licensed or certified nonphysician persons or qualified laser technicians who perform medical aesthetic services delegated by a medical director.

13.6(2) Delegation by a medical director. A medical aesthetic service shall only be performed by qualified licensed or certified nonphysician persons or qualified laser technicians if the service has been delegated by a medical director who is responsible for supervision of the services performed at a medical spa in Iowa. Nothing in this rule shall be interpreted to prevent a qualified nonphysician licensed health professional from serving as a medical director at a medical spa or from appropriately delegating medical aesthetic services pursuant to the rules of the professional’s licensing authority.

13.6(3) Medical director. A medical director at a medical spa shall:

- a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;
- b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;
- c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and
- e. Be clearly identified as the medical director in all advertising activities, Internet websites and signage related to the medical spa.

13.6(4) Delegated medical aesthetic service. When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians, the service shall be:

- a. Within the medical director’s scope of practice and medical competence to supervise;
- b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and
- c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

13.6(5) Supervision. A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians is responsible for providing appropriate supervision. The medical director shall:

- a. Ensure that all licensed or certified nonphysician persons or qualified laser technicians are qualified and competent to safely perform each delegated medical aesthetic service by personally assessing the person’s education, training, experience and ability;
- b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services that are beyond the scope of that person’s license or certification unless the person is supervised by a qualified supervising physician or other qualified supervising nonphysician licensed health professional;
- c. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician or other qualified supervising nonphysician licensed health professional at least four hours each week and that the regular supervision is documented;
- d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- e. Be physically located, at all times, within 60 miles of the location where delegated medical aesthetic services are performed;

f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services, particularly in case of injury or an emergency;

g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services;

h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving delegated medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

i. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians maintain accurate and timely medical records for the delegated medical aesthetic services they perform;

j. Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or certified nonphysician persons or qualified laser technicians and that such informed consent is timely documented in the patient's medical record;

k. Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians, and all qualified licensed or certified nonphysician persons or qualified laser technicians are visibly displayed at each medical spa where they perform medical aesthetic services and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

l. Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services at a medical spa, within 14 days of a request by the board.

13.6(6) Continuing medical education. A medical director shall complete and shall ensure that all other physicians, qualified licensed or certified nonphysician persons, and qualified laser technicians who practice at the medical spa complete a minimum of 20 hours of continuing medical education in the safe and effective performance of medical aesthetic services each year.

13.6(7) Exceptions. This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

13.6(8) Other qualified nonphysician licensed health professionals. Nothing in this rule shall be interpreted to contradict or supersede the rules established in 481—Chapters 617, 621, 780 and 781.

653—13.7(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

13.7(1) Definition. As used in this rule:

“Interventional chronic pain management” means diagnosing and treating pain-related disorders using interventional techniques for subacute, chronic, persistent, and intractable pain. These techniques include percutaneous needle placement for drug injection, nerve ablation, and certain surgeries. Common procedures involve injecting steroids, analgesic, and anesthetics into targeted areas such as the spine, joints, or nerves. This may include lumbar, thoracic, and cervical spine injections; nerve blocks; and processes like vertebroplasty. Fluoroscopy is used to assess chronic pain causes or aid in identifying anatomical landmarks during these techniques. Specific procedures include joint injections, nerve blocks, epidural injections, and nerve destruction.

13.7(2) Interventional chronic pain management. The practice of interventional chronic pain management shall include the following:

- a. Comprehensive assessment of the patient;
- b. Diagnosis of the cause of the patient's pain;
- c. Evaluation of alternative treatment options;

- d. Selection of appropriate treatment options;
- e. Termination of prescribed treatment options when appropriate;
- f. Follow-up care; and
- g. Collaboration with other health care providers.

13.7(3) *Practice of medicine.* Interventional chronic pain management is the practice of medicine.

653—13.8(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.

13.8(1) *Definition.* As used in this rule:

“Abortion-inducing drug” means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

13.8(2) *Review of patient record.* A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first reviewed the lab results, ultrasound images, and medical history provided by the patient to determine, and document in the woman’s medical record, the gestational age and intrauterine location of the pregnancy. A physician may utilize telemedicine pursuant to rule 653—13.9(147,148,272C).

13.8(3) *Follow-up appointment required.* If an abortion is induced by an abortion-inducing drug, the physician or designee shall use all reasonable efforts to ensure a follow-up appointment is scheduled with the patient at the same facility within 12 to 18 days after the patient’s use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman’s medical condition.

13.8(4) *Parental notification regarding pregnant minors.* A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L).

653—13.9(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

13.9(1) *Definitions.* As used in this rule:

“Asynchronous store-and-forward transmission” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

“Board” means the Iowa board of medicine.

“In-person encounter” means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

“Licensee” means a medical physician or osteopathic physician licensed by the board.

“Telemedicine” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

“Telemedicine technologies” means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

13.9(2) *Practice guidelines.* A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice

guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.9(3) *Iowa medical license required.* A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653—subrule 9.2(2).

13.9(4) *Standards of care and professional ethics.* A licensee who uses telemedicine is held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.9(5) *Scope of practice.* A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

13.9(6) *Identification of patient and physician.* A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.9(7) *Physician-patient relationship.*

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

- (1) The person with a health-related matter seeks assistance from a licensee;
- (2) The licensee agrees to undertake diagnosis and treatment of the person; and
- (3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

- (1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;
- (2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care; or
- (3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

13.9(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.9(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

13.9(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.9(11) *Coordination of care.* A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.9(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.9(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.9(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.9(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, August 21, 1996, 110 Stat. 1936, and any amendments as of October 16, 2024, to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

- (1) Privacy;
- (2) Health care personnel who will process messages;
- (3) Hours of operation;
- (4) Types of transactions that will be permitted electronically;
- (5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;
- (6) Archiving and retrieval; and
- (7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.9(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

- a.* Comply with relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;
- b.* Be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and
- c.* Be compliant with the Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, August 21, 1996, 110 Stat. 1936, and any amendments as of October 16, 2024.

13.9(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

- a.* Types of services provided;
- b.* Contact information for the licensee;
- c.* Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;
- d.* Limitations in the drugs and services that can be provided via telemedicine;
- e.* Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;
- f.* Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);
- g.* Appropriate uses and limitations of the technologies, including in emergency situations;
- h.* Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;
- i.* To whom patient health information may be disclosed and for what purpose;
- j.* Rights of patients with respect to patient health information; and
- k.* Information collected and passive tracking mechanisms utilized.

13.9(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

- a.* To access, supplement and amend patient-provided personal health information;
- b.* To provide feedback regarding the quality of the telemedicine services provided; and
- c.* To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.9(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.9(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

- a.* Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;
- b.* For institutional settings, including writing initial admission orders for a newly hospitalized patient;
- c.* Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

- d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- e. Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;
- f. Emergency situations in which the life or health of the patient is in imminent danger;
- g. Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;
- h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and
- i. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

13.9(21) *Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an Internet request or Internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 13.9(20).

653—13.10(135,147,148,272C,280) Standards of practice—prescribing epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility.

13.10(1) Definition. For purposes of this rule:

“Authorized facility” means a facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school.

13.10(2) Notwithstanding any other provision of law to the contrary, a physician may prescribe epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A.

13.10(3) A physician who prescribes epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A, provided the physician has acted reasonably and in good faith, is not liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists.

653—13.11(144E,147,148,272C) Standards of practice—experimental treatments for patients with a terminal illness.

13.11(1) *Exemption from discipline.* To the extent consistent with state law, the board will not revoke, fail to renew, suspend, or take any action against a physician's license based solely on the physician's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

13.11(2) *Eligible patient.* A physician shall ensure that a patient meets all of the following conditions prior to the use of an investigational drug, biological product, or device pursuant to this rule:

- a. The patient has a terminal illness, attested to by the patient's treating physician.
- b. The patient has considered and rejected or has tried and failed to respond to all other treatment options approved by the U.S. Food and Drug Administration (FDA).

c. The patient has received a recommendation from the patient's physician for an investigational drug, biological product, or device.

d. The patient has given written informed consent for the use of the investigational drug, biological product, or device.

e. The patient has documentation from the patient's physician that the patient meets the requirements of this rule.

13.11(3) *Investigational drug, biological product, or device.* A physician may recommend access to or treatment with an investigational drug, biological product, or device that has successfully completed phase 1 of an FDA-approved clinical trial but has not yet been approved for general use by the FDA and remains under investigation in an FDA-approved clinical trial.

13.11(4) *Terminal illness.* A physician shall ensure that a patient has a terminal illness prior to the use of an investigational drug, biological product, or device pursuant to this rule. A terminal illness is a progressive disease or medical or surgical condition that entails significant functional impairment and that is not considered by a treating physician to be reversible even with administration of treatments approved by the FDA and that, without life-sustaining procedures, will result in death.

13.11(5) *Written informed consent.* A physician shall obtain written informed consent prior to the use of an investigational drug, biological product, or device pursuant to this rule. Written informed consent is a written document that is signed by a patient, a parent of a minor patient, or a legal guardian or other legal representative of the patient and attested to by the patient's treating physician and a witness and that includes all of the following:

a. An explanation of the products and treatments approved by the FDA for the disease or condition from which the patient suffers.

b. An attestation that the patient concurs with the patient's treating physician in believing that all products and treatments approved by the FDA are unlikely to prolong the patient's life.

c. Clear identification of the specific proposed investigational drug, biological product, or device that the patient is seeking to use.

d. A description of the best and worst potential outcomes of using the investigational drug, biological product, or device and a realistic description of the most likely outcome. The description to include the possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by use of the proposed investigational drug, biological product, or device. The description is based on the treating physician's knowledge of the proposed investigational drug, biological product, or device in conjunction with an awareness of the patient's condition.

e. A statement that the patient's health plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless the patient's health plan or third-party administrator and provider are specifically required to do so by law or contract.

f. A statement that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.

g. A statement that the patient understands that the patient is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the patient's estate unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

13.11(6) *Assisting suicide.* This rule is not to be construed to allow a patient's treating physician to assist the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

13.11(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of this rule or 653—Chapter 23. Grounds for discipline include but are not limited to the following:

a. The physician recommends access to or treatment with an investigational drug, biological product, or device to an individual who is not an eligible patient pursuant to this rule.

- b. The physician fails to obtain appropriate written informed consent prior to recommending access to or treatment with an investigational drug, biological product, or device pursuant to this rule.
- c. The physician assists the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

653—13.12(147,148,272C) Standards of practice—tick-borne disease diagnosis and treatment.

13.12(1) Exemption from discipline. A person licensed by the board under Iowa Code chapter 148 shall not be subject to discipline under this chapter or the board's enabling statute based solely on the physician's recommendation or provision of a treatment method for Lyme disease or other tick-borne disease if the recommendation or provision of such treatment meets all the following criteria:

- a. The treatment is provided after an examination is performed and informed consent is received from the patient.
- b. The physician identifies a medical reason for recommending or providing the treatment.
- c. The treatment is provided after the physician informs the patient about other recognized treatment options and describes to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne disease.
- d. The physician uses the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.
- e. The treatment will not, in the opinion of the physician, result in the direct and proximate death of or serious bodily injury to the patient.

13.12(2) Lyme disease treatment. Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics. Over the past several years, the International Lyme and Associated Diseases Society (ILADS) has supported longer courses of antibiotics for some patients, versus the prescribed treatment durations identified by the Infectious Diseases Society of America (IDSA) and referenced by the CDC. While IDSA has expressed concern about overtreatment, ILADS points out that treatment decisions should be based on a risk-benefit analysis. Both groups have published evidence-based guidelines.

13.12(3) Tick-borne diseases. According to the CDC, tick-borne diseases include:

- a. *Anaplasmosis* is transmitted to humans by tick bites primarily from the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the United States (U.S.) and the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.
- b. *Babesiosis* is caused by microscopic parasites that infect red blood cells. Most human cases of babesiosis in the U.S. are caused by *Babesia microti*. *Babesia microti* is transmitted by the blacklegged tick (*Ixodes scapularis*) and is found primarily in the northeastern and upper midwestern regions of the U.S.
- c. *Borrelia mayonii* infection has recently been described as a cause of illness in the upper midwestern region of the U.S. This infection has been found in blacklegged ticks (*Ixodes scapularis*) in Minnesota and Wisconsin. *Borrelia mayonii* is a new species and is the only species besides *B. burgdorferi* known to cause Lyme disease in North America.
- d. *Borrelia miyamotoi* infection has recently been described as a cause of illness in the U.S. This infection is transmitted by the blacklegged tick (*Ixodes scapularis*) and has a geographic range similar to that of Lyme disease.
- e. *Bourbon virus* infection has been identified in a limited number of patients in the midwestern and southern regions of the U.S. At this time, it is not known if the virus might be found in other areas of the U.S.
- f. *Colorado tick fever* is caused by a virus transmitted by the Rocky Mountain wood tick (*Dermacentor andersoni*). Colorado tick fever occurs in the Rocky Mountain states at elevations of 4,000 to 10,500 feet.
- g. *Ehrlichiosis* is transmitted to humans by the lone star tick (*Amblyomma americanum*), found primarily in the south central and eastern regions of the U.S.

h. *Heartland virus* cases have been identified in the midwestern and southern regions of the U.S. Studies suggest that lone star ticks (*Amblyomma americanum*) can transmit the virus. It is unknown if the virus may be found in other areas of the U.S.

i. *Lyme disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the U.S. and by the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

j. *Powassan disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) and the groundhog tick (*Ixodes cookei*). Cases have been reported primarily from northeastern states and the Great Lakes region.

k. *Rickettsia parkeri rickettsiosis* is transmitted to humans by the Gulf Coast tick (*Amblyomma maculatum*).

l. *Rocky Mountain spotted fever* is transmitted by the American dog tick (*Dermacentor variabilis*), Rocky Mountain wood tick (*Dermacentor andersoni*), and the brown dog tick (*Rhipicephalus sanguineus*) in the U.S. The brown dog tick and other tick species are associated with Rocky Mountain spotted fever in Central America and South America.

m. *Southern tick-associated rash illness* is transmitted via bites from the lone star tick (*Amblyomma americanum*) found in the southeastern and eastern regions of the U.S.

n. *Tick-borne relapsing fever* is transmitted to humans through the bite of infected soft ticks. Tick-borne relapsing fever has been reported in 15 states: Arizona, California, Colorado, Idaho, Kansas, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Utah, Washington, and Wyoming and is associated with sleeping in rustic cabins and vacation homes.

o. *Tularemia* is transmitted to humans by the dog tick (*Dermacentor variabilis*), the wood tick (*Dermacentor andersoni*), and the lone star tick (*Amblyomma americanum*). Tularemia occurs throughout the U.S.

p. *364D rickettsiosis (Rickettsia phillipi)* is transmitted to humans by the Pacific Coast tick (*Dermacentor occidentalis*). This is a new disease that has been found in California.

13.12(4) Grounds for discipline. A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician fails to perform and document an appropriate examination or fails to obtain and document appropriate informed consent from the patient.

b. The physician fails to identify and document a medical reason for recommending or providing the treatment.

c. The physician fails to inform the patient about other recognized treatment options or fails to describe to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne diseases.

d. The physician fails to use the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment provided, in the opinion of the physician, will likely result in the direct and proximate death of or serious bodily injury to the patient.

653—13.13(124E,147,148,272C) Standards of practice—medical cannabidiol.

13.13(1) Definitions. For purposes of this rule:

"*Bordering state*" means the same as defined in Iowa Code section 331.910.

"*Debilitating medical condition*" means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.

3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:

- Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson's disease.
 9. Chronic pain.
 10. Ulcerative colitis.
 11. Severe, intractable autism with self-injurious or aggressive behaviors.
 12. Corticobasal degeneration.
 13. Post-traumatic stress disorder.

"Department" means the Iowa department of public health.

"Form and quantity" means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

"Medical cannabidiol" means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and adopted by the department pursuant to rule.

"Medical cannabidiol board" means the board established pursuant to Iowa Code section 124E.5.

"Primary caregiver" means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of this chapter.

"Untreatable pain" means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

"Written certification" means a document signed by a physician licensed pursuant to Iowa Code chapter 148 with whom the patient has established a patient-physician relationship and who is the patient's primary care provider that states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

13.13(2) *Written certification.* A physician who is a patient's primary care provider may provide the patient a written certification of diagnosis if, after examining and treating the patient, the physician determines, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

a. The physician shall provide explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

b. Subsequently, the physician shall do the following:

(1) Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, may issue the patient a new written certification of that diagnosis.

(2) Otherwise comply with all requirements established by the department pursuant to rule.

c. A physician may provide, but has no duty to provide, a written certification pursuant to this rule.

13.13(3) *Adding or removing debilitating medical conditions and amending form and quantity of medical cannabidiol.* Recommendations made by the medical cannabidiol board pursuant to Iowa

Code section 124E.5 relating to the addition or removal of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial or to the amendment of the form and quantity of allowable medical uses of cannabidiol shall be made to the board of medicine for consideration. The medical cannabidiol board shall submit a written recommendation, a copy of the petition and all other information received during consideration of the petition. The board of medicine shall consider the information received from the medical cannabidiol board and may seek information from other sources if it is deemed relevant by the board of medicine. The decision regarding a recommendation by the medical cannabidiol board is at the sole discretion of the board of medicine. The board of medicine shall make its decision within 180 days of receipt of the recommendation from the medical cannabidiol board. If the recommendation is approved by the board of medicine, it shall be adopted by rule.

13.13(4) *Financial interests.* A physician shall not share office space with, accept referrals from, or have any financial relationship with a medical cannabidiol manufacturer or dispensary.

13.13(5) *Criminal prosecution.* A physician, including any authorized agent or employee thereof, shall not be subject to prosecution for the unlawful certification, possession, or administration of marijuana under the laws of this state for activities arising directly out of or directly related to the certification or use of medical cannabidiol in the treatment of a patient diagnosed with a debilitating medical condition as authorized by Iowa Code chapter 124E.

13.13(6) *Civil or disciplinary penalties.* A physician, including any authorized agent or employee thereof, shall not be subject to any civil or disciplinary penalties by the board of medicine or any business, occupational, or professional licensing board or entity, solely for activities conducted relating to a patient's possession or use of medical cannabidiol as authorized by Iowa Code chapter 124E. Nothing in this rule prevents the board of medicine from taking action in response to violations of any other sections of law or rule.

13.13(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include but are not limited to the following:

a. The physician provides an individual a written certification without establishing a patient-physician relationship, including examining and treating the individual, or without being the individual's primary care provider.

b. The physician provides a patient a written certification without determining, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

c. The physician provides a patient a written certification without providing explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

d. The physician provides an individual a new written certification without determining, on an annual basis, that the patient continues to suffer from a debilitating medical condition.

e. The physician shares office space with, accepts referrals from, or has a financial relationship with a medical cannabidiol manufacturer or dispensary.

653—13.14(146A) Abortion prerequisites.

13.14(1) *Written certification.* At least 24 hours prior to performing an abortion, a physician shall obtain written certification from the pregnant woman of each prerequisite as required in Iowa Code sections 146A.1(1)"a" through 146A.1(1)"d"(1). The written certification shall list each required prerequisite separately and shall include a line for date and signature of the pregnant woman. The physician shall maintain a copy of the certification as part of the pregnant woman's medical records.

13.14(2) *Exceptions.* This rule shall not apply to abortions performed in a medical emergency, as provided in Iowa Code section 146A.1(2).

13.14(3) Discipline. Failure to comply with this rule or the requirements of Iowa Code section 146A.1 may constitute grounds for discipline.

653—13.15(135L,146A,146E,147,148,272C) Standards of practice for physicians who perform or induce abortions—definitions—detection of fetal heartbeat—fetal heartbeat exceptions—discipline.

13.15(1) Standards of practice. This rule sets forth the standards of practice for physicians who perform or induce abortions. More information is contained in Iowa Code section 146E.2(5).

13.15(2) Definitions. As used in this rule or in Iowa Code chapter 146E:

“*Private health agency*” means any establishment, facility, organization, or other entity that is not owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

“*Public health agency*” means any establishment; facility; organization; administrative division; or entity that is owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, administrative divisions, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

“*Standard medical practice*” means the degree of skill, care, and diligence that a physician of the same medical specialty would employ in like circumstances. As applied to the method used to determine the presence of a fetal heartbeat for purposes of Iowa Code chapter 146E and this rule, “standard medical practice” includes employing the appropriate means of detection depending on the estimated gestational age of the unborn child and the condition of the woman and her pregnancy.

“*The pregnancy is the result of a rape*” means a circumstance in which the pregnancy is the result of conduct that would constitute an offense under Iowa Code section 709.2, 709.3, 709.4, or 709.4A when perpetrated against a female, regardless of where the conduct occurred.

“*The pregnancy is the result of incest*” means a circumstance in which a sex act occurs between closely related persons that involves a vaginal penetration that causes a pregnancy. The closely related persons must be related, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew. For purposes of this rule, a closely related person includes a stepparent, stepchild, or stepsibling, including siblings through adoption.

“*Unborn child*” means an individual organism of the species *Homo sapiens* from fertilization to live birth—that is, at all stages of development, including embryo and fetus.

“*Woman*” means a female individual regardless of her age.

13.15(3) Detection of fetal heartbeat. A physician who intends to perform or induce an abortion must determine via ultrasound whether the woman is carrying an unborn child with a detectable fetal heartbeat.

a. Obligation. The obligation under this rule requires a bona fide effort to detect a fetal heartbeat in the unborn child. This effort must be made in good faith and according to standard medical practice and reasonable medical judgment.

b. Method. The physician shall perform a transabdominal pelvic ultrasound on the woman to determine whether the unborn child has a detectable fetal heartbeat. This shall be performed in a

manner consistent with standard medical practice, with real-time ultrasound equipment with a transducer of appropriate frequency. The equipment must be properly maintained and in proper functioning order.

13.15(4) *Fetal heartbeat exceptions.* The following applies to a physician who intends to perform or induce an abortion under a fetal heartbeat exception as defined in Iowa Code chapter 146E and this rule:

a. Incest or rape. For purposes of this rule, a pregnancy resulting from incest or rape may be reported within the appropriate time frame to a licensed physician whose services are retained for an abortion procedure.

(1) To determine whether the pregnancy is the result of incest, a physician who intends to perform or induce an abortion must use the following information:

1. Whether the sex act occurred between the woman and a closely related person, meaning, either legitimately or illegitimately, an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, including a stepparent, stepchild, or stepsibling to include an adopted sibling.

2. The date the act occurred.

3. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the act was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for incest applies. This information does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

(2) To determine whether the pregnancy is the result of a rape, a physician who intends to perform or induce an abortion must use the following information:

1. The date the sex act that caused the pregnancy occurred.

2. The age of the woman seeking an abortion at the time of that sex act.

3. Whether the sex act constituted a rape.

4. Whether the rape was perpetrated against the woman seeking an abortion.

5. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the rape was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for rape applies. This rule does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

b. Fetal abnormality. A certification from an attending physician that a fetus has a fetal abnormality that in the attending physician's reasonable medical judgment is incompatible with life must contain the following information:

(1) The diagnosis of the abnormality;

(2) The basis for the diagnosis, including the tests and procedures performed, the results of those tests and procedures, and why those results support the diagnosis; and

(3) A description of why the abnormality is incompatible with life.

The diagnosis and the attending physician's conclusion must be reached in good faith following a bona fide effort, consistent with standard medical practice and reasonable medical judgment, to determine the health of the fetus. The certification must be signed by the attending physician. A physician who intends to perform or induce an abortion may rely in good faith on a certification from an attending physician if the physician who intends to perform or induce an abortion has a copy of the certification. The certification must be included in the woman's medical records by the physician who intends to perform or induce an abortion.

13.15(5) *Discipline.* Failure to comply with this rule or the requirements of Iowa Code chapter 146E may constitute grounds for discipline.

653—13.16(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association is utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

13.16(1) *Conflict of interest.* A physician should not provide medical services under terms or conditions that tend to interfere with or impair the free and complete exercise of the physician's medical judgment and skill or tend to cause a deterioration of the quality of medical care.

13.16(2) *Fees.* Any fee charged by a physician shall be reasonable.

653—13.17(147A) Emergency medical care provider. A physician with a license in good standing may be staffed on an authorized emergency medical services (EMS) program provided the physician can document equivalency through education and additional skills training essential in the delivery of out-of-hospital emergency care. The equivalency shall be accepted when documentation has been reviewed and approved at the local level by the medical director of the authorized EMS service program and the department of health and human services bureau of emergency medical and trauma services in accordance with the form adopted by the department of health and human services.

These rules are intended to implement Iowa Code chapters 124, 124E, 144E, 146E, 148 and 272C and sections 147.55, 148.6, 147.107, 272C.3 and 272C.4.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 17
“Licensure of Acupuncturists”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 147, 148, 148E and 272C
State or federal law(s) implemented by the rulemaking: Iowa Code chapters 17A, 147, 148, 148E and 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa
Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking sets minimum standards for entry into the profession for acupuncturists. Iowa residents, licensees, and employers benefit from the chapter since it articulates the processes by which individuals apply for licensure as an acupuncturist in the state of Iowa, including initial licensure, renewal, and reactivation. These requirements ensure public safety by specifying that all individuals entering the profession have minimum competency.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There is no direct cost to the general public, but there is a cost to the applicant since complying with the minimum requirements to enter into the profession is at the expense of the licensee.

The licensee would also have costs related to educational requirements and examination requirements. The Board of Medicine has not identified an exact cost of education for this field because it varies depending on the school the licensee chooses to attend to meet those requirements.

Board staff review applications for initial and renewal licenses, answer inquiries on licensing, and field phone calls. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The public and professionals benefit from the proposed rulemaking. Establishing minimum licensing requirements ensures that practitioners are competent to practice. Without having an established threshold for entry into the profession, individuals who are not appropriately trained could cause serious harm to the public during their practice. Acupuncturists require certain skills and training to effectively help and treat their patients.

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:

Educational institutions provide the academic training for physicians to obtain their license in the state of Iowa. Additional private industries and educational institutions provide examinations and materials for preparation for the examination. Because the cost of education is so variable depending on the institution the person attends, the Board is unable to put an exact cost on the cost of education or examination preparation. Licensing fees are \$345 for initial licensing and \$300 for renewal.

- Qualitative description of impact:

Establishing minimum requirements for licensure ensures safety for the licensee and consumer. The cost of inaction would be increasing the potential for injury to the public by a licensee who is not qualified to perform the work in the field.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage Board activities, which include managing applications for initial licenses, renewals, and reinstatements. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

- Anticipated effect on state revenues:

Costs associated with implementing this chapter are paid by individual licensees or establishments, not the State. This rulemaking has no anticipated impact on state revenues.

Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of acupuncturists. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

6. Alternative methods considered by the agency:

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

The Board has not identified a more cost-effective alternative to the licensure of acupuncturists. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of acupuncturists. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario. In addition, the chapter provides consistency related to the licensure of providers in other states, which makes obtaining licensure in multiple states simpler for applicants.

Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort. The Department is actively pursuing a single licensing platform to assist in standardizing licensing.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 17 and adopt the following **new** chapter in lieu thereof:

CHAPTER 17 LICENSURE OF ACUPUNCTURISTS

653—17.1(148E) Scope of chapter. The rules in this chapter only apply to individuals licensed under Iowa Code chapter 148E. In accordance with Iowa Code section 148E.3, the rules in this chapter do not apply to the following:

1. A person otherwise licensed by the state to practice medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatry, or dentistry who is exclusively engaged in the practice of the person's profession.
2. A student practicing acupuncture under the direct supervision of a licensed acupuncturist as part of a course of study approved by the board.

653—17.2(148E) Definitions. The definitions stated in Iowa Code section 148E.1 apply to this chapter, in addition to those listed below.

“Accreditation Commission for Acupuncture and Oriental Medicine” or *“ACAOM”* means the United States-based accreditation commission that certifies acupuncture and oriental medicine training programs and colleges.

“Acupuncture needle” means a solid-core instrument including but not limited to acupuncture needles, dermal needles, intradermal needles, press tacks, plum blossom needles, prismatic needles, and disposable lancets.

“Acupuncture point” means a specific anatomical location on the human body that serves as the treatment site for the use of acupuncture.

“Applicant” means a person not otherwise authorized to practice acupuncture under Iowa Code section 148E.3 who applies to the board for a license.

“Ashi acupuncture point” means an acupuncture point that is located according to tenderness upon palpation. An ashi acupuncture point is also known as a trigger point.

“Committee” means the licensure committee of the board with oversight responsibility for administration of the licensure of acupuncturists.

“Department” means the department of inspections, appeals, and licensing.

“Disclosure sheet” means the written information licensed acupuncturists must provide to patients on initial contact.

“Disposable needles” means presterilized needles that are discarded after initial use pursuant to Iowa Code section 148E.5.

“License” means a license issued by the board pursuant to Iowa Code section 148E.2.

“Licensee” means a person holding a license to practice acupuncture issued by the board pursuant to Iowa Code chapter 148E.

“National Certification Commission for Acupuncture and Oriental Medicine” or *“NCCAOM”* means the United States-based commission that validates entry-level competency in the practice of acupuncture and oriental medicine through professional certification.

653—17.3(147,148E) Eligibility for licensure.

17.3(1) Eligibility requirements. To be licensed to practice acupuncture by the board, a person shall meet all of the following requirements:

- a. Fulfill all the application requirements as specified in 653—17.4(147,148E).
- b. Hold current active status as a diplomate in NCCAOM or, after June 1, 2004, hold current active status as a diplomate in acupuncture or oriental medicine from NCCAOM.
- c. Demonstrate sufficient knowledge of the English language to understand and be understood by patients and board and committee members.
 - (1) An applicant who passed the NCCAOM written and practical examination components in English may be presumed to have sufficient proficiency in English.
 - (2) An applicant who passed NCCAOM written or practical examination components in a language other than English shall pass the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) examinations administered by the Educational Testing Service.
- d. Successfully complete a three-year postsecondary training program or acupuncture college program that is accredited by, in candidacy for accreditation by, or that meets the standards of the Accreditation Commission for Acupuncture and Oriental Medicine.
- e. Successfully complete a course in clean needle technique approved by the NCCAOM.
- f. The applicant’s license is not denied by the board due to the commission of a disqualifying offense, as provided in 653—subrule 9.3(3).

17.3(2) Waiver prohibited. Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

653—17.4(147,148E) Application requirements.

17.4(1) *Application for licensure.* To apply for a license to practice acupuncture, an applicant shall:

- a.* Submit the completed application form provided by the board, including required credentials and documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;
- b.* Pay the nonrefundable initial application fee identified in 653—subrule 8.2(1); and
- c.* Pay the fee identified in 653—subrule 8.2(5) for the evaluation of the fingerprint packet and the national criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

17.4(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

- a.* The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;
- b.* A chronology accounting for all time periods from the date the applicant entered an acupuncture and oriental medicine training program or college to the date of the application;
- c.* The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice acupuncture, including license, certificate of registration or certification numbers, and date of issuance;
- d.* Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories. Copies of the legal documents may be requested if needed during the review process;
- e.* A statement disclosing and explaining any informal or nonpublic actions, warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, acupuncture or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;
- f.* A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;
- g.* The NCCAOM score report verification form submitted directly to the board by the NCCAOM;
- h.* An NCCAOM certificate that demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM;
- i.* Proof of successful completion of a course in clean needle technique approved by the NCCAOM;
- j.* A description of the applicant's clinical acupuncture training, work experience and, where applicable, supporting documentation;
- k.* A copy of the applicant's acupuncture degree issued by an educational institution. If a copy of the acupuncture degree cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained an acupuncture degree from a specific educational institution;
- l.* A complete translation of any diploma not written in English. An official transcript, written in English and received directly from the educational institution, showing graduation from an acupuncture training program or an educational institution is a suitable alternative;
- m.* A sworn statement from an official of the educational institution certifying the date the applicant received the acupuncture degree and acknowledging what, if any, derogatory comments exist in the institution's record about the applicant. If a sworn statement from an official of the educational institution cannot be provided because of extraordinary circumstances, the board may accept other reliable evidence that the applicant obtained an acupuncture degree from a specific educational institution;

n. An official transcript sent directly from an acupuncture training program or an educational institution attended by the applicant and, if requested by the board, an English translation of the official transcript;

o. Proof of the applicant's proficiency in the English language, when the applicant has not passed the English version of the NCCAOM written and practical examinations;

p. Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board; and

q. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

17.4(3) *Application cycle.* If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application is inactive.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—subrule 8.2(2) and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, applicants must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

17.4(4) *Applicant responsibilities.* An applicant for licensure to practice acupuncture bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national testing or credentialing organizations, health facilities, and educational institutions providing the information specified in subrule 17.4(2);

b. Providing accurate, up-to-date, and truthful information on the application form, including but not limited to that specified under subrule 17.4(2) related to prior professional experience, education, training, examination scores, diplomate status, licensure or registration, and disciplinary history; and

c. Submitting English translations of documents in foreign languages bearing the affidavit of the translator certifying that the translation is a true and complete translation of the foreign language original. The applicant shall bear the expense of the translation.

17.4(5) *Licensure application review process.* The process below is utilized to review each application. Priority is given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

a. An application for initial licensure is considered open from the date the application form is received in the board office with the nonrefundable initial application fee.

b. After reviewing each application, staff will notify the applicant about how to resolve any problems identified by the reviewer. An applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and the director of legal affairs will determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff will administratively grant the license.

- (2) If any concern exists, the application will be referred to the committee.
- e. Staff will refer to the committee for review matters that include but are not limited to: falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.
- f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to issue the license administratively.
- g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee will recommend that the board:
- (1) Request an investigation;
 - (2) Request that the applicant appear for an interview;
 - (3) If an applicant has not engaged in active practice in the past three years in any jurisdiction of the United States, require an applicant to:
 1. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;
 2. Successfully pass a competency evaluation approved by the board;
 3. Successfully pass an examination approved by the board; or
 4. Successfully complete a reentry to practice program or monitoring program approved by the board;
 - (4) Issue a license;
 - (5) Issue a license under certain terms and conditions or with certain restrictions;
 - (6) Request that the applicant withdraw the licensure application; or
 - (7) Deny a license.
- h. The board will consider applications and recommendations from the committee and will:
- (1) Request an investigation;
 - (2) Request that the applicant appear for an interview;
 - (3) If an applicant has not engaged in active practice in the past three years in any jurisdiction of the United States, require an applicant to:
 1. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;
 2. Successfully pass a competency evaluation approved by the board;
 3. Successfully pass an examination approved by the board; or
 4. Successfully complete a reentry to practice program or monitoring program approved by the board;
 - (4) Issue a license;
 - (5) Issue a license under certain terms and conditions or with certain restrictions;
 - (6) Request that the applicant withdraw the licensure application; or
 - (7) Deny a license. The board may deny a license for any grounds on which the board may discipline a license.

17.4(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in rule 653—17.3(147,148E) as authorized by Iowa Code section 148E.2 or of this chapter.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148E.8 or in 481—Chapter 8.

17.4(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board will issue a preliminary notice of denial that will be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and cites the factual and legal basis for denying the application, notifies the applicant of the appeal process, and specifies the date upon which the denial will become final if it is not appealed.

17.4(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by

serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board will consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

17.4(9) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing will be a contested case open to the public and conducted in accordance with 481—Chapter 506.

17.4(10) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 17.4(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

17.4(11) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with subrule 17.4(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice will state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

17.4(12) *Waiver prohibited.* Provisions of this rule are not subject to waiver pursuant to 481—Chapter 6 or any other provision of law.

653—17.5(147,148E,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148E.2, a license expires on October 31 of even-numbered years and can be renewed for the fee identified in 653—paragraph 8.2(2)“c.” The applicant for renewal shall provide an NCCAOM certificate that demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM.

17.5(1) *Expiration date.* Certificates of licensure to practice acupuncture expire on October 31 in even years.

17.5(2) *Prorated fees.* The first renewal fee for a license will be prorated on a monthly basis according to the date of issue.

17.5(3) *Renewal requirements and penalties for late renewal.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

a. Upon receipt of the completed renewal application, staff will administratively issue a license that expires on October 31 of even-numbered years. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.

b. Every renewal shall be displayed in connection with the original certificate of licensure.

c. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty stated in 657—paragraph 8.2(2)“g” will be assessed for renewal in the grace period, a period up until January 1.

17.5(4) *Inactive license.* Failure of a licensee to renew by January 1 will result in inactivation of the license, and the license will be invalid.

a. Licensees are prohibited from engaging in the practice of acupuncture with an inactive or lapsed license.

b. Having an acupuncturist license in lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148E.8.

653—17.6(147,272C) Reactivation of an inactive license.

17.6(1) *Reactivation requirements.* Licensees who allow their licenses to go inactive by failing to renew may apply for reactivation of a license. Pursuant to Iowa Code section 147.11, applicants for reactivation shall:

a. Submit completed application for reactivation of a license to practice acupuncture. The application shall include the following information:

(1) The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, acupuncture or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction.

(5) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(6) A chronology accounting for all time periods from the date of initial licensure.

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—subrule 8.2(5) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reactivation fee identified in rule 653—8.2(147,148,272C) plus the fee identified in 653—subrule 8.2(5) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. Provide an NCCAOM certificate which demonstrates that the applicant holds current active status as a diplomate in acupuncture or oriental medicine from the NCCAOM.

e. Meet any new requirements instituted since the license lapsed.

17.6(2) *Reactivation restrictions.* Pursuant to Iowa Code section 272C.3(2)“*d.*” the committee may require an applicant who has not engaged in active practice in the past three years in any jurisdiction of the United States to meet any or all of the following requirements prior to reactivation of a license:

a. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

b. Successfully pass a competency evaluation approved by the board;

c. Successfully pass an examination approved by the board; or

d. Successfully complete a reentry to practice program or monitoring program approved by the board.

653—17.7(272C) Continuing education requirements. Licensees shall demonstrate that they hold current active status as a diplomate from the NCCAOM. The NCCAOM requires 60 points of professional development activity every four years. Active NCCAOM certification satisfies the continuing education requirements established in Iowa Code section 272C.2.

653—17.8(147,148E,272C) General provisions.

17.8(1) *Diagnostic and treatment modalities.* Diagnostic and treatment modalities used by licensees under this chapter may include one or more of the following acupunctural services:

a. The stimulation or piercing of the skin with an acupuncture needle for any of the following purposes:

- (1) To evoke a therapeutic physiological response, either locally or distally to the area of insertion or stimulation.
- (2) To relieve pain or treat the neuromusculoskeletal system.
- (3) To stimulate ashi acupuncture points to relieve pain and dysfunction.
- (4) To promote, maintain, and restore health and to prevent disease.
- (5) To stimulate the body according to auricular, hand, nose, face, foot or scalp acupuncture therapy.
- (6) To use acupuncture needles with or without the use of herbs, electric current, or application of heat.

b. The use of oriental medical diagnosis and treatment, including:

- (1) Moxibustion, cupping, thermal methods, magnets, gua sha scraping techniques, acupatches, herbal poultices, hot and cold packs, electromagnetic wave therapy, light and color therapy, sound therapy, or therapy lasers.
- (2) Massage, acupressure, reflexology, shiatsu and tui na massage, or manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin.
- (3) Herbal medicine and dietary supplements, including those of plant, mineral, animal, and nutraceutical origin.

c. Any other adjunctive service or procedure that is clinically appropriate based on the licensee's training as approved by NCCAOM or ACAOM.

17.8(2) *Use and disposal of needles.* A licensee shall use only presterilized, disposable needles and shall provide for the disposal of used needles in accordance with the requirements of the department.

17.8(3) *Standard of care.* A licensee shall be held to the same standard of care as persons licensed to practice medicine and surgery or osteopathic medicine and surgery. Pursuant to Iowa Code section 272C.3, any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care in the practice of acupuncture constitutes malpractice and is grounds for the revocation or suspension of a license to practice acupuncture in this state.

17.8(4) *Title.* An acupuncturist licensed under this title may use the words "licensed acupuncturist" or "L.Ac." to connote professional standing after the licensee's name in accordance with Iowa Code section 147.74(18).

17.8(5) *Change of contact information.* Licensees shall notify the board of changes in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board within one month of the change.

17.8(6) *Delegation of responsibilities.* A licensee shall perform all aspects of acupuncture treatment that involve penetration of the skin of a patient. The licensee may delegate other aspects of treatment to staff and patients who are properly trained by the licensee. It is permissible for appropriately trained staff and patients to remove acupuncture needles from the patient's body. The licensee is responsible for establishing and maintaining written training standards for staff.

17.8(7) *Change of full legal name.* A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

17.8(8) *Deceased.* A licensee's file will be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.

These rules are intended to implement Iowa Code chapter 148E and sections 17A.10 through 17A.20, 147.55, 272C.3 through 272C.6, 272C.8 and 272C.9.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 19
“Prescribing Psychologists”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 124, 147, 148, 154B and 272C
State or federal law(s) implemented by the rulemaking: Iowa Code chapters 148 and 154B

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa
Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking details the supervision required of a psychologist who prescribes medications to patients. The chapter lays out the requirements that must be met related to the supervising physician, the training and education required, and requirements of the psychologist. This chapter helps ensure that the public receives competent and safe care from the practitioner.

Cross-references to 481—Chapter 883 are to that chapter as proposed to be adopted in the 10/2/24 Iowa Administrative Bulletin.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There are no direct costs to the public directly attributable to this chapter. There may be an incalculable cost of supervision that may tangentially increase the cost of the care the psychologist provides.

Costs to the agency are for the staff time needed to manage the full scope of Board of Medicine activities, which include oversight of practice standards, answering questions from licensees and the public, administration of Board meetings, etc. An executive officer supports the work of this Board at approximately 0.15 full-time equivalent (FTE) position.

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

The general public and licensees benefit from this chapter since it ensures oversight of prescribing practices for psychologists. Without the oversight, the care received by the public would not be supervised by a medical doctor who has specialized training in prescribing psychotropic medications. This chapter creates the standards and safeguards to ensure safety of the public.

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:

There are no direct costs to the public directly attributable to the chapter. There may be an incalculable cost of supervision that may tangentially increase the cost of the care the psychologist provides.

Costs to the agency are the staff time needed to manage the full scope of Board activities, which includes oversight of practice standards, answering questions from licensees and the public, administration of board meetings, etc. An executive officer supports the work of this Board at approximately 0.15 FTE position.

- Qualitative description of impact:

Establishing practice standards ensures safety for the licensee and the consumer. If there was no supervision of prescribing psychologists, it could mean patients receiving incorrect psychotropic medications or harm to patients. These regulations help ensure standards are followed by the psychologists prescribing medications and adequate supervision of the prescribing practices is utilized.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage the full scope of Board activities, which include oversight of practice standards, answering questions from licensees and the public, administration of Board meetings, etc. An executive officer supports the work of this Board at approximately 0.15 FTE position.

- Anticipated effect on state revenues:

This rule has no anticipated impact on state revenues. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes the benefit is being achieved since the chapter provides guidelines for practice that licensees must abide by, which therefore serves to protect the public. Without this oversight, the care the public receives would not be supervised by a medical doctor who has specialized training in prescribing psychotropic medications. There would also not be the standards and safeguards in place to ensure safety of patients.

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

Because the Board is required to promulgate rules for the prescribing practices of psychologists, inaction is not an option. The Board believes that the proposed rules are the most effective and efficient implementation of the Iowa Code and that the rules provide for the safety and welfare of the public.

6. Alternative methods considered by the agency:

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

The Board has not identified any alternative methods to implement the statutory requirements.

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

The Board is required to promulgate rules for the prescribing practices of psychologists; therefore, inaction was not an option. The Board has not identified any alternative methods to implement the statutory requirements.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large corporation. The chapter is meant to ensure public safety in terms of standards and supervision of prescribing psychologists. While some licensees could be running a small business, some also work for large hospitals, clinics and retailers. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 19 and adopt the following **new** chapter in lieu thereof:

CHAPTER 19 PRESCRIBING PSYCHOLOGISTS

653—19.1(148,154B) Joint rules adopted. The board of medicine adopts and incorporates the following rules as its own: 481—883.1(148,154B), 481—883.3(148,154B), 481—883.4(148,154B), 481—883.6(148,154B) through 481—883.8(148,154B), and 481—883.11(148,154B) through 481—883.13(148,154B).

653—19.2(17A,124,147,148,154B,272C) Standards of practice—supervision of a conditional prescribing psychologist. A supervising physician shall be a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician's normal course of practice and who supervises a conditional prescribing psychologist. A supervising physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A supervising physician shall fully comply with the following standards of practice.

19.2(1) Supervision. During supervised practice, a supervising physician oversees a conditional prescribing psychologist to ensure patient safety and optimal outcomes. This includes ensuring proper

clinical examinations, necessary testing, and appropriate psychopharmacology services for the patient's condition. Supervision can occur in person or electronically according to these rules.

19.2(2) *Primary supervising physician.* A supervising physician shall determine whether the supervising physician has been designated as a conditional prescribing psychologist's primary supervising physician and fulfills the responsibilities of the primary supervising physician in accordance with these rules. A conditional prescribing psychologist may have more than one supervising physician.

19.2(3) *Maximum number of conditional prescribing psychologists.* A supervising physician cannot supervise more than two conditional prescribing psychologists at one time.

19.2(4) *Minimum period of supervision.* The primary supervising physician shall ensure that a conditional prescribing psychologist completes a minimum of two years of supervised practice prescribing psychotropic medications to patients with mental disorders in accordance with these rules in order for the conditional prescribing psychologist to be eligible to apply for a prescription certificate.

19.2(5) *Minimum number of patients.* The primary supervising physician shall ensure that a conditional prescribing psychologist has seen a minimum of 300 patients who had a diagnosed mental disorder for whom pharmacological intervention was considered as a treatment option, even if a decision was made not to prescribe a psychotropic medication to the patient. The primary supervising physician shall ensure that a conditional prescribing psychologist has treated a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

19.2(6) *Initial assessment.* Prior to supervising a conditional prescribing psychologist, each supervising physician shall assess the conditional prescribing psychologist's relevant education, training, experience, and competence.

19.2(7) *Scope of practice.* Each supervising physician shall ensure that all psychopharmacology services provided by a conditional prescribing psychologist are within the competence and scope of practice of the supervising physician and the conditional prescribing psychologist.

19.2(8) *Prescriptive authority.* Each supervising physician shall ensure that a conditional prescribing psychologist only prescribes psychotropic medications for the treatment of mental disorders.

19.2(9) *Prescriptions.* A supervising physician shall ensure that each prescription issued by a conditional prescribing psychologist identifies the prescriber as a "psychologist certified to prescribe" and includes the Iowa license number of the conditional prescribing psychologist and the name of the supervising physician.

19.2(10) *Active DEA and CSA registration.* A supervising physician shall ensure that a conditional prescribing psychologist has an active DEA registration and CSA registration at all times during the period of supervision.

19.2(11) *Patient populations.* A supervising physician shall ensure that a conditional prescribing psychologist only provides psychopharmacology services to patient populations within the conditional prescribing psychologist's education, training, experience, and competence. A supervising physician may establish limitations on the types of populations to whom a conditional prescribing psychologist may provide psychopharmacology services based on the conditional prescribing psychologist's education, training, experience, and competence.

19.2(12) *Psychotropic medications.* A supervising physician shall ensure that a conditional prescribing psychologist only prescribes psychotropic medications that are within the conditional prescribing psychologist's education, training, experience, and competence. A supervising physician may establish limitations on the types of psychotropic medications that a conditional prescribing psychologist may prescribe based on the conditional prescribing psychologist's education, training, experience, and competence.

19.2(13) *Specialization.* A supervising physician shall ensure that a conditional prescribing psychologist has completed the following training during the supervised practice period to be eligible to prescribe psychotropic medications to the respective population as a prescribing psychologist:

a. Children. To prescribe to patients who are less than 17 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

- (1) A pediatric practice,
- (2) A child and adolescent practice, or
- (3) A general practice provided the conditional prescribing psychologist treats a minimum of 50 patients who are less than 17 years of age.

b. Elderly patients. To prescribe to patients who are over 65 years of age, a conditional prescribing psychologist shall complete at least one year of the required two years of supervised practice in either:

- (1) A geriatric practice, or
- (2) A general practice with patients across the lifespan including patients who are over 65 years of age.

c. Serious medical conditions. To prescribe to patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, a supervising physician shall ensure that a conditional prescribing psychologist has completed at least one year prescribing psychotropic medications to patients with serious medical conditions if the conditional prescribing psychologist intends to treat patients with serious medical conditions after the supervised practice period.

19.2(14) *Informed consent.* A supervising physician shall ensure that a conditional prescribing psychologist obtains appropriate informed consent before the conditional prescribing psychologist provides psychopharmacology services to a patient.

19.2(15) *Release of information.* A supervising physician shall ensure that a conditional prescribing psychologist obtains a release of information authorizing the conditional prescribing psychologist to share information with the supervising physician before the conditional prescribing psychologist provides psychopharmacology services to a patient.

19.2(16) *Primary care physician.* A supervising physician shall ensure that each patient has a designated primary care physician before a conditional prescribing psychologist provides psychopharmacology services to a patient. A supervising physician shall ensure that a conditional prescribing psychologist maintains a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed. A supervising physician shall ensure that a conditional prescribing psychologist engages in appropriate consultation with a patient's designated primary care physician while the conditional prescribing psychologist is providing psychopharmacology services to a patient.

19.2(17) *Chart reviews.* A supervising physician shall personally review a representative sample of the conditional prescribing psychologist's patient charts.

19.2(18) *Performance evaluations.* A supervising physician shall regularly evaluate the clinical judgment, skills and performance of a conditional prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the conditional prescribing psychologist.

19.2(19) *Supervision plan.* Before supervising a conditional prescribing psychologist, a supervising physician must ensure there is an approved written supervision plan. This plan should outline the supervisory relationship, including review parameters, and consider both parties' education, training, and experience and the psychopharmacology services involved. A template is available from the boards of medicine and psychology. Both the supervising physician and the psychologist must keep a copy of the plan and provide it to the boards if requested. The supervision plan shall include the following:

a. Conditional prescribing psychologist's information. The name, license number, address, telephone number, and email address of the conditional prescribing psychologist.

b. Supervising physician's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the supervising physician.

c. Designation of the primary supervising physician. Designation of the conditional prescribing psychologist's primary supervising physician.

d. Period of supervision. The beginning date of the supervision plan and estimated date of completion.

e. Locations and settings. A description of the locations and settings where and with whom supervision will occur.

f. Scope of practice. A description of the scope of practice of the supervising physician and the conditional prescribing psychologist.

g. Methods of communication. A description of how the supervising physician and conditional psychologist may communicate for appropriate supervision.

h. Initial assessment. A description of the steps the supervising physician has taken to assess a conditional prescribing psychologist's relevant education, training, experience, and competence prior to supervising the conditional prescribing psychologist.

i. Limitations on psychotropic medications. A description of any limitations on the types of psychotropic medications the conditional prescribing psychologist may prescribe consistent with the supervising physician's and prescribing psychologist's relevant education, training, experience, and competence.

j. Limitations on patient populations. A description of any limitations on the types of populations the conditional prescribing psychologist may treat with psychotropic medications consistent with the supervising physician's and prescribing psychologist's relevant education, training, experience, and competence.

k. Expectations and responsibilities. A description of the expectations and responsibilities of the supervisory relationship.

l. Specialization. A description of the specialized training to be completed by the conditional prescribing psychologist in order to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities in accordance with rule 481—883.4(148,154B).

m. Chart reviews. A description of the steps the supervising physician has taken to personally review a representative sample of the conditional prescribing psychologist's patient charts.

n. Consultation between the supervising physician and the primary care physician. A requirement that the supervising physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

o. Performance evaluations. A description of the steps the supervising physician has taken to regularly evaluate the clinical judgment, skills and performance of a conditional prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the conditional prescribing psychologist.

p. Termination of the supervision plan. A description of how the supervision plan may be terminated and the process for notifying affected patients.

q. Signatures. Signatures of the conditional prescribing psychologist and all supervising physicians.

r. Amendment to the supervision plan. A requirement that a conditional prescribing psychologist shall inform the board of psychology of any amendments to the supervision plan, including the addition of any supervising physicians, within 30 days of the change and that any amendment to a supervisory plan be subject to approval of the board of psychology.

s. Request for extension. If the primary supervising physician determines that a conditional prescribing psychologist is unable to successfully complete the supervised practice prior to the

expiration of the conditional prescription certificate, the conditional prescribing psychologist may request an extension of the conditional prescription certificate provided that the conditional prescribing psychologist and the primary supervising physician can demonstrate that the conditional prescribing psychologist is likely to successfully complete the supervised practice within the extended time requested.

19.2(20) *Certification of completion.* At the conclusion of the supervised practice period, the primary supervising physician shall certify the following:

a. Supervision. That each supervising physician has provided supervision to the conditional prescribing psychologist in accordance with these rules.

b. Minimum period of supervised practice. That the conditional prescribing psychologist has successfully completed a minimum of two years of supervised practice.

c. Minimum number of patients. That the conditional prescribing psychologist has seen a minimum of 300 patients who had a diagnosed mental disorder with whom pharmacological intervention was considered as a treatment option, even if a decision was made not to prescribe a psychotropic medication to the patient, and that the conditional prescribing psychologist has treated a minimum of 100 patients with psychotropic medication throughout the supervised practice period.

d. Specialization. That a conditional prescribing psychologist who intends to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities, has successfully completed a minimum of one year of supervised practice with the respective populations during the supervised practice period.

e. Demonstrated competence. That a conditional prescribing psychologist has successfully completed the supervised practice period and demonstrated competence in psychopharmacology by demonstrating competency in the milestones sufficient to obtain a prescription certificate in accordance with 481—subrule 883.3(2).

653—19.3(17A,124,147,148,154B,272C) Standards of practice—collaboration with a prescribing psychologist. A collaborating physician shall be a person who is licensed to practice medicine and surgery or osteopathic medicine in Iowa, who regularly prescribes psychotropic medications for the treatment of mental disorders as part of the physician's normal course of practice, and who serves as a resource for a prescribing psychologist pursuant to a collaborative practice agreement. A collaborating physician shall be board-certified in family medicine, internal medicine, neurology, pediatrics, or psychiatry. A collaborating physician shall fully comply with the following standards of practice:

19.3(1) *Collaboration.* A collaborating physician shall provide appropriate collaboration with a prescribing psychologist to achieve patient safety and optimal clinical outcomes. A collaborating physician shall ensure that appropriate clinical examinations and necessary testing are performed and that all psychopharmacology services provided are appropriate for the patient's condition. Collaboration may be in person or via electronic communications in accordance with these rules. A prescribing psychologist may have more than one collaborating physician.

19.3(2) *Maximum number of prescribing psychologists.* A physician shall not serve as a collaborating physician for more than two prescribing psychologists at one time.

19.3(3) *Initial assessment.* Prior to serving as a collaborating physician, a physician shall assess a prescribing psychologist's relevant education, training, experience, and competence.

19.3(4) *Scope of practice.* A collaborating physician shall ensure that all psychopharmacology services provided by a prescribing psychologist are within the competence and scope of practice of the collaborating physician and the prescribing psychologist.

19.3(5) *Prescriptive authority.* A collaborating physician shall ensure that a prescribing psychologist only prescribes psychotropic medications for the treatment of mental disorders.

19.3(6) *Delegation.* A collaborating physician shall ensure that a prescribing psychologist does not delegate prescriptive authority to any other person.

19.3(7) *Narcotics.* A collaborating physician shall ensure that a prescribing psychologist does not prescribe narcotics.

19.3(8) *Active DEA and CSA registration.* A collaborating physician shall ensure that a prescribing psychologist has an active DEA registration and CSA registration at all times during the period of collaboration.

19.3(9) *Patient populations.* A collaborating physician shall ensure that a prescribing psychologist only provides psychopharmacology services to patient populations within the prescribing psychologist's education, training, experience, and competence. A collaborating physician may establish limitations on the types of populations to whom a prescribing psychologist may provide psychopharmacology services based on the prescribing psychologist's education, training, experience, and competence.

19.3(10) *Psychotropic medications.* A collaborating physician shall ensure that a prescribing psychologist only prescribes psychotropic medications that are within the prescribing psychologist's education, training, experience, and competence. A collaborating physician may establish limitations on the types of psychotropic medications that a prescribing psychologist may prescribe based on the prescribing psychologist's education, training, experience, and competence.

19.3(11) *Specialization.* A collaborating physician shall ensure that a prescribing psychologist has completed at least one year of the required two years of supervised practice with the respective population in accordance with rule 481—883.4(148,154B) before the prescribing psychologist provides psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities.

19.3(12) *Informed consent.* A collaborating physician shall ensure that a prescribing psychologist obtains appropriate informed consent before a prescribing psychologist provides psychopharmacology services to a patient.

19.3(13) *Release of information.* A collaborating physician shall ensure that a prescribing psychologist obtains a release of information authorizing the prescribing psychologist to share information with the collaborating physician before the prescribing psychologist provides psychopharmacology services to a patient.

19.3(14) *Primary care physician.* A collaborating physician shall ensure that each patient has a designated primary care physician before a prescribing psychologist provides psychopharmacology services to a patient. A collaborating physician shall ensure that a prescribing psychologist maintains a cooperative relationship with the primary care physician who oversees a patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed. A collaborating physician shall ensure that a prescribing psychologist engages in appropriate consultation with a patient's designated primary care physician while the prescribing psychologist is providing psychopharmacology services to a patient.

19.3(15) *Chart reviews.* A collaborating physician shall personally review a representative sample of the prescribing psychologist's patient charts.

19.3(16) *Performance evaluations.* A collaborating physician shall regularly evaluate the clinical judgment, skills and performance of a prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the prescribing psychologist.

19.3(17) *Collaborative practice agreement.* Prior to serving as a collaborating physician for a prescribing psychologist, the collaborating physician shall ensure that the prescribing psychologist has a written collaborative practice agreement in place. A template may be obtained from the boards of medicine and psychology. The collaborative practice agreement shall define the nature and extent of the collaborative relationship and outline specific parameters for review of the collaborative relationship. The collaborative practice agreement shall take into account the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence and the nature

and scope of the psychopharmacology services to be provided. The collaborating physician shall review the terms of the collaborative practice agreement with the prescribing psychologist at least once each year. The collaborating physician and prescribing psychologist shall each maintain a copy of the collaborative practice agreement and provide a copy of the agreement to the boards of medicine and psychology upon request. The collaborative practice agreement shall include the following:

a. Prescribing psychologist's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the prescribing psychologist.

b. Collaborating physician's information. The name, license number, DEA registration number, CSA registration number, address, telephone number, email address, and practice locations of the collaborating physician.

c. Period of collaboration. The time period covered by the collaborative practice agreement.

d. Locations and settings. A description of the locations and settings where and with whom collaborative practice will occur.

e. Scope of practice. A description of the scope of practice of the collaborating physician and the prescribing psychologist.

f. Methods of communication. A description of how the collaborating physician and prescribing psychologist may communicate for appropriate collaboration.

g. Initial assessment. A description of the steps the collaborating physician has taken to assess a prescribing psychologist's relevant education, training, experience, and competence prior to collaborating with a prescribing psychologist.

h. Limitations on psychotropic medications. A description of any limitations on the types of psychotropic medications the prescribing psychologist may prescribe consistent with the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence.

i. Limitations on patient populations. A description of any limitations on the types of populations the prescribing psychologist may treat with psychotropic medications consistent with the collaborating physician's and prescribing psychologist's relevant education, training, experience, and competence.

j. Expectations and responsibilities. A description of the expectations and responsibilities of the collaborative relationship.

k. Specialization. A description of the specialized training the prescribing psychologist has completed in order to provide psychopharmacology services to children (less than 17 years of age), elderly persons (over 65 years of age), or patients with serious medical conditions, including but not limited to, heart disease, cancer, stroke, seizures, or comorbid psychological conditions, or patients with developmental disabilities and intellectual disabilities in accordance with rule 481—883.4(148,154B).

l. Chart reviews. A description of the steps the collaborating physician has taken to personally review a representative sample of the prescribing psychologist's patient charts.

m. Consultation between the collaborating physician and the primary care provider. A requirement that the collaborating physician consult with the patient's primary care physician on a regular basis regarding the patient's psychotropic treatment plan and any potential complications.

n. Performance evaluations. A description of the steps the collaborating physician has taken to regularly evaluate the clinical judgment, skills and performance of the prescribing psychologist to safely provide psychopharmacology services to patients and provide appropriate feedback to the prescribing psychologist.

o. Termination of the collaborative practice agreement. A provision describing how the collaborative practice agreement may be terminated and the process for notifying affected patients.

p. Signatures. Signatures of the collaborating physician and the prescribing psychologist.

653—19.4(17A,124,147,148,272C) Grounds for discipline. A physician who fails to comply with these rules may be subject to disciplinary action by the board of medicine.

These rules are intended to implement Iowa Code chapters 148 and 154B.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 20
“Licensure of Genetic Counselors”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147, 148H and 272C

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147, 148, 148H and 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking sets minimum standards for entry into the medical profession. Iowa residents, licensees and employers benefit from the rulemaking since it articulates the processes by which individuals apply for licensure as a genetic counselor in the state of Iowa, as directed in statute. This includes the processes for initial licensure, renewal, and reactivation. These requirements ensure public safety by requiring individuals entering the profession to have minimum competency.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There is no direct cost to the general public, but there is a cost to the applicant since complying with the minimum requirements to enter into the profession is at the expense of the licensee.

The licensee would also have costs related to educational requirements and examination requirements. The Board of Medicine has not identified an exact cost of education for this field since it varies depending on the school the licensee chooses to attend to meet those requirements.

Board staff review applications for initial and renewal licenses, answer inquiries on licensing, and field phone calls. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The public and professionals benefit from the proposed rulemaking. Establishing minimum licensing requirements ensures that practitioners are competent to practice. Without having an established threshold for entry into the profession, individuals who are not appropriately trained could cause serious harm to the public during their practice. Genetic counselors and medical professionals require certain skills and training to effectively help and treat their patients.

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:

Educational institutions provide the academic training for genetic counselors to obtain their license in the state of Iowa. Additional private industries and educational institutions provide examinations and materials for preparation for the examination. Because the cost of education is so variable depending on the institution the person attends, the Board is unable to put an exact cost on education or examination preparation.

Licensing fees are \$245 for initial licensing and \$200 for renewal.

- Qualitative description of impact:

Establishing minimum requirements for licensure ensures safety for the licensee and consumer. The cost of inaction would be increasing the potential for injury to the public by a licensee who is not qualified to perform the work in the field.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage Board activities, which include managing applications for initial licenses, renewals, and reinstatements. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

- Anticipated effect on state revenues:

Costs associated with implementing this rulemaking are paid by individual licensees or establishments, not the State. This rulemaking has no anticipated impact on state revenues.

Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of genetic counselors. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

6. Alternative methods considered by the agency:

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

The Board has not identified a more cost-effective alternative to the licensure of genetic counselors. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for

the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

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

The Board has not identified a more cost-effective alternative to the licensure of genetic counselors. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. Licensure requirements could be reduced or eliminated for the purpose of lowering the bar of entry into the profession, but the Board would be concerned about the public safety of Iowans in that scenario.

Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort. The Department is actively pursuing a single licensing platform to assist in standardizing licensing.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 20 and adopt the following **new** chapter in lieu thereof:

CHAPTER 20 LICENSURE OF GENETIC COUNSELORS

653—20.1(148H) Scope of chapter. This chapter does not apply to any of the following:

1. A physician or surgeon or an osteopathic physician or surgeon licensed under Iowa Code chapter 148, a registered nurse or an advanced registered nurse practitioner licensed under Iowa Code chapter 152, a physician assistant licensed under Iowa Code chapter 148C, or other persons licensed

under Iowa Code chapter 147 when acting within the scope of the person's profession and doing work of a nature consistent with the person's education and training.

2. A person who is certified by the American Board of Medical Genetics and Genomics as a doctor of philosophy and is not a genetic counselor licensed pursuant to Iowa Code chapter 148H.

3. A person employed as a genetic counselor by the federal government or an agency thereof if the person provides genetic counseling services solely under the direction and control of the entity by which the person is employed.

4. A genetic counseling intern.

653—20.2(148H) Definitions. The definitions stated in Iowa Code chapter 148H, in addition to those listed below, apply to this chapter.

“American Board of Genetic Counseling” or *“ABGC”* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

“American Board of Medical Genetics and Genomics” or *“ABMGG”* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

653—20.3(148H) Titles used. A genetic counselor licensed under Iowa Code chapter 148H may use the words “genetic counselor” or “licensed genetic counselor” or the corresponding abbreviation “LGC” after the person's name. Persons who possess a provisional license shall add the designation “provisional licensed genetic counselor.”

653—20.4(148H) Qualifications for licensure.

20.4(1) Each applicant for licensure under Iowa Code chapter 148H shall:

- a. Submit an application form and supporting documentation.
- b. Hold active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

20.4(2) A licensee shall maintain active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

653—20.5(148H) Qualifications for provisional licensure. The board may issue a provisional license to an applicant who meets all of the requirements for licensure except for the certification component and who has been granted active candidate status by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

20.5(1) The applicant shall submit a provisional license application form, proof of active candidate status, and supporting documentation prescribed by the board.

20.5(2) A provisional license expires and becomes inactive upon the earliest of the following:

- a. Issuance of a license as a genetic counselor by the board.
- b. Loss of active candidate status.
 - (1) A person holding a provisional license that is inactive due to loss of active candidate status may submit an application for reactivation of the provisional license upon demonstrating that active candidate status has been reestablished.

- (2) An application for extension of a provisional license shall be signed by a qualified supervisor.

- c. The date printed on the provisional license.

20.5(3) A person with a provisional license shall work at all times under the supervision of a qualified supervisor.

653—20.6(147,148H) Application requirements.

20.6(1) *Application for licensure.* To apply for a license to practice genetic counseling, an applicant shall:

a. Submit the completed application, including required credentials and documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

b. Pay the nonrefundable initial application fee identified in 653—subrule 8.13(1) and pay the fee identified in 653—subrule 8.13(6) for the evaluation of the fingerprint packet and the national criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

20.6(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

a. The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

b. A chronology accounting for all time periods from the date the applicant entered a genetic counseling training program or educational institution to the date of the application;

c. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice genetic counseling, including license, certificate of registration or certification number and date of issuance;

d. Full disclosure of the applicant's involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process;

e. A statement disclosing and explaining any informal or nonpublic actions, such as letters of warning, letters of education, any confidential retraining, or any kind of confidential action taken toward a genetic counselor's certification or license that is not public discipline; warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;

f. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

g. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure;

h. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

20.6(3) *Application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application is inactive.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—subrule 8.13(2) and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, an applicant must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

20.6(4) *Applicant responsibilities.* An applicant for licensure to practice genetic counseling bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national certifying organizations, health facilities, and educational institutions providing the information specified in subrule 20.6(2);

b. Providing accurate, up-to-date, and truthful information on the application form including but not limited to that specified under subrule 20.6(2) related to prior professional experience, education, training, active certification, licensure, and disciplinary history.

20.6(5) *Licensure application review process.* Licensure applications will be reviewed pursuant to the process outlined in rule 653—9.8(147,148).

20.6(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, and after consultation with an Iowa-licensed genetic counselor, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in this chapter pursuant to Iowa Code section 148H.3.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148H.7 or in rule 653—20.20(147,148H,272C).

20.6(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board issues a preliminary notice of denial that is sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and cites the factual and legal basis for denying the application, notifies the applicant of the appeal process, and specifies the date upon which the denial will become final if it is not appealed.

20.6(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board considers the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

20.6(9) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing will be a contested case open to the public and conducted in accordance with 481—Chapter 506.

20.6(10) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 20.6(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

20.6(11) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with subrule 20.6(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice will state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

20.6(12) *Waiver prohibited.* Provisions of this rule are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

653—20.7(147,148H) Display of license and notification required to change the board's data system.

20.7(1) *Display of license.* Licensed genetic counselors shall display the license issued by the board in a conspicuous place in their primary place of business.

20.7(2) *Change of contact information.* Licensees shall notify the board within one month of a change in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board.

20.7(3) *Change of full legal name.* A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

20.7(4) *Deceased.* A licensee's file will be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.

653—20.8(147,148H,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148H.3, a license expires on October 31 of odd-numbered years and can be renewed for the fee identified in 653—paragraph 8.14(2)"c."

20.8(1) *Application.* The applicant for renewal shall provide:

- a. A renewal application.
- b. A letter sent directly from the ABGC or ABMGG to the board verifying that the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.
- c. Satisfactory evidence to the board that in the period since the license was issued or last renewed, the applicant has completed 30 hours of National Society of Genetic Counselors or ABMGG continuing education units as approved by the board.

20.8(2) *Expiration date.* Certificates of licensure to practice genetic counseling expires on October 31 in odd years.

20.8(3) *Prorated fees.* The first renewal fee for a license will be prorated on a monthly basis according to the date of issue.

20.8(4) *Renewal requirements and penalties for late renewal.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

a. Upon receipt of the completed renewal application, staff will administratively issue a license that expires on October 31 of odd-numbered years. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.

b. Every renewal shall be displayed in connection with the original certificate of licensure.

c. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty fee identified in 653—subrule 8.13(4) will be assessed for renewal in the grace period, a period up until January 1.

20.8(5) *Inactive license.* Failure of a licensee to renew by January 1 will result in inactivation of the license, and the license will become invalid.

a. Licensees are prohibited from engaging in the practice of genetic counseling with an inactive or lapsed license.

b. Having a genetic counselor license in inactive or lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148H.7.

653—20.9(147,272C) Reactivation of an inactive license.

20.9(1) *Reactivation requirements.* Licensees who allow their licenses to go inactive by failing to renew may apply for reactivation of a license. Pursuant to Iowa Code section 147.11, applicants for reactivation shall:

a. Submit a completed application for reactivation of a license to practice genetic counseling. The application shall include the following information:

(1) The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant's involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority; an educational institution; a training or research program; or a health facility in any jurisdiction.

(5) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(6) A chronology accounting for all time periods from the date of initial licensure.

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—subrule 8.13(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reactivation fee identified in 653—subrule 8.13(7) plus the fee identified in 653—subrule 8.13(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from the ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

e. Meet any new requirements instituted since the license lapsed.

20.9(2) *Reactivation for an applicant who has been out of practice for three years.* If an applicant for reactivation has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

a. Successfully complete board-approved continuing education or remediation.

b. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board.

c. Successfully complete any other pathway as agreed upon by the board.

653—20.10(272C) Code of ethics. The NSGC Code of Ethics prepared and approved by the National Society of Genetic Counselors shall be utilized by the board as guiding principles in the practice of genetic counseling in this state.

653—20.11(148H,272C) Surrender of license to the board.

20.11(1) A genetic counselor whose ABGC certification has lapsed or whose certification has been revoked by the ABGC shall surrender the genetic counselor's license to the board.

20.11(2) A provisional licensee who loses active candidate status with the ABGC must immediately cease the practice of genetic counseling until the provisional licensee obtains an extension of the provisional license or obtains a new provisional license.

These rules are intended to implement Iowa Code chapters 147, 148, 148H, and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 21
“Physician Supervision of a Physician Assistant”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 147, 148C and 272C
State or federal law(s) implemented by the rulemaking: Iowa Code sections 148C.3 and 272C.3

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa
Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This rulemaking proposes the repromulgation of Chapter 21 and implements Iowa Code section 148C.5 as amended by 2023 Iowa Acts, House File 424, in accordance with the goals and directives of Executive Order 10 (January 10, 2023). Iowa Code section 148C.3 requires the Board of Medicine (Board) to adopt joint rules with the Board of Physician Assistants requiring a licensed physician assistant to be supervised by a physician during the first two years of independent practice if the physician assistant has not previously practiced under a supervising physician or in collaboration therewith for a period of at least two years. This chapter sets minimum standards for the supervision of a physician assistant by a physician. Iowa residents, licensees and employers benefit from the chapter since it articulates the processes by which a physician assistant can practice under the supervision of a physician during the first two years of independent practice.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:

There is no direct cost to the general public, but there is a cost to the applicant since complying with the minimum requirements to enter into the profession is at the expense of the licensee.

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. The cost would be for a small portion of the Board’s standard meetings during which investigative reports are reviewed for action determination.

Costs to the agency are in the form of staff time to review supervisory agreements if needed, investigate complaints if necessary, and answer questions related to supervision of physician assistants. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557.

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

Iowa residents, licensees, and employers benefit from the chapter since it articulates the processes by which a physician assistant can practice under the supervision of a physician during the first two years of independent practice. These requirements ensure public safety by specifying all requirements of supervisory agreements.

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:

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. The cost would be for a small portion of the Board's standard meetings during which investigative reports are reviewed for action determination.

- Qualitative description of impact:

Iowa residents, licensees, and employers benefit from the chapter since it articulates the processes by which a physician assistant can practice under the supervision of a physician during the first two years of independent practice. These requirements ensure public safety by specifying all requirements of supervisory agreements.

3. Costs to the State:

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

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. Costs to the agency are in the form of staff time to review supervisory agreements if needed, investigate complaints if necessary, and answer questions related to supervision of physician assistants. Staff salaries to support the work of the Board are covered by the fund.

- Anticipated effect on state revenues:

This rulemaking has no anticipated impact on state revenues. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. The cost would be a small portion of the Board's standard meetings during which investigative reports are reviewed for action determination. The requirements in the rules ensure public safety by specifying all requirements of supervisory agreements. Without these rules, the Board would be concerned that physician assistants would not have proper training and supervision, which could cause public harm.

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

The Board has not identified a more cost-effective alternative to the physician supervision of a physician assistant. The Board believes all current requirements ensure public safety and ensure a minimum competency of care is provided to Iowans. The Board is currently working with the Board of Physician Assistants to create joint rules for supervision and collaboration pursuant to 2023 Iowa Acts, House File 424.

Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The changes to this chapter support this effort.

6. Alternative methods considered by the agency:

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

The Board has not identified alternative methods for physician supervision of a physician assistant. The Board is currently working with the Board of Physician Assistants to create joint rules for supervision and collaboration pursuant to the changes made from 2023 Iowa Acts, House File 424.

Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize Board processes across all professional licensing boards.

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

The Board is currently working with the Board of Physician Assistants to create joint rules for supervision and collaboration pursuant to the changes made from 2023 Iowa Acts, House File 424.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 21 and adopt the following **new** chapter in lieu thereof:

CHAPTER 21

PHYSICIAN SUPERVISION OF A PHYSICIAN ASSISTANT

653—21.1(148,272C) Ineligibility determinants. A physician with an active permanent, special, or temporary Iowa license who is actively engaged in the practice of medicine in Iowa may supervise a physician assistant. A physician is ineligible to supervise a physician assistant for any of the following reasons:

21.1(1) The physician does not hold an active, permanent, special or temporary Iowa medical license.

21.1(2) The physician is subject to a disciplinary order of the board that restricts or rescinds the physician's authority to supervise a physician assistant. The physician may supervise a physician assistant to the extent that the order allows.

21.1(3) The physician does not have a written supervisory agreement in place with each physician assistant supervised by the physician.

21.1(4) The physician is already supervising five physician assistants.

653—21.2(148,272C) Exemptions from this chapter. This chapter does not apply to the following:

21.2(1) A physician working in a federal facility or under federal authority when the provisions of this chapter conflict with federal regulations.

21.2(2) A physician who supervises a physician assistant providing medical care created by an emergency or a state or local disaster pursuant to Iowa Code section 148C.4.

653—21.3(148) Board notification. A physician who supervises a physician assistant shall notify the board of the supervisory relationship within 60 days of the provision of initial supervision and at the time of the physician's license renewal.

653—21.4(148,272C) Supervisory agreements.

21.4(1) A physician who supervises a physician assistant shall establish a written supervisory agreement prior to supervising a physician assistant. The purpose of the supervisory agreement is to define the nature and extent of the supervisory relationship and the expectations of each party. The supervisory agreement shall take into account the physician assistant's demonstrated skills, training and experience, proximity of the supervising physician to the physician assistant, and the nature and scope of the medical practice. The supervising physician shall maintain a copy of the supervisory agreement and provide a copy of the agreement to the board upon request. The supervisory agreement shall, at a minimum, address the following provisions:

a. Review of requirements. The supervising physician and the physician assistant shall review all of the requirements of physician assistant licensure, practice, supervision, and delegation of medical services as set forth in Iowa Code section 148.13 and chapter 148C, these rules, and 481—Chapters 780 through 784.

b. Assessment of education, training, skills, and experience. Each supervising physician shall assess the education, training, skills, and relevant experience of the physician assistant prior to providing supervision. Each supervising physician and physician assistant shall ensure that the other party has the appropriate education, training, skills, and relevant experience necessary to successfully collaborate on patient care delivered by the team. The method for assessing and providing feedback regarding the physician assistant's education, training, skills, and experience shall be reflected in the supervisory agreement.

21.4(2) The supervisory agreement between the physician assistant and the physician shall address all of the following:

a. The medical services the supervising physician delegates to the physician assistant. The medical services and medical tasks delegated to and provided by the physician assistant shall be in compliance with 481—subrule 781.1(1). All delegated medical services shall be within the scope of practice of the supervising physician and the physician assistant.

b. Methods for communication between the physician assistant and the physician and whether the physician assistant practices at the same site or a remote site. Each supervising physician and physician assistant shall conduct ongoing discussions and evaluation of the supervisory agreement, including supervision; expectations for both parties; assessment of education, training, skills, and relevant experience; review of delegated services; review of the medical services provided by the physician assistant; and the types of cases and situations when the supervising physician expects to be consulted.

(1) The plan for completing and documenting chart reviews. A licensed physician within the same facility or health care system as the physician assistant shall conduct an ongoing review of a representative sample of the physician assistant's patient charts encompassing the scope of the physician assistant's practice. The finding of the review shall be discussed with the physician assistant in a manner determined by the practice in consultation with the physician assistant's primary supervising physician.

(2) Remote medical site. "Remote medical site" means a medical clinic for ambulatory patients that is more than 30 miles away from the main practice location of the supervising physician and in which the supervising physician is present less than 50 percent of the time when the remote medical site is open. "Remote medical site" will not apply to nursing homes, patient homes, hospital outpatient departments, outreach clinics, or any location at which medical care is incidentally provided (e.g., diet center, free clinic, site for athletic physicals, jail facility). The supervisory agreement shall include a provision that ensures that the supervising physician visits the remote medical site, or communicates with a physician assistant at the remote medical site via electronic communications, at least every two weeks to provide additional medical direction, medical services and consultation specific to the medical services provided at the remote medical site. For purposes of this subparagraph, communication may consist of but is not limited to in-person meetings or two-way, interactive communication directly between the supervising physician and the physician assistant via the telephone, secure messaging, electronic mail, or chart review. The board may only grant a waiver of this provision if substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in this subparagraph.

(3) The expectations and plan for alternate supervision. The supervising physician will ensure that the alternate supervising physician is available for a timely consultation and will ensure that the physician assistant is notified of the means by which to reach the alternate supervising physician.

653—21.5(148,272C) Grounds for discipline. A physician may be subject to disciplinary action for supervising a physician assistant in violation of these rules or the rules found in 653—Chapter 23 or 481—Chapters 780 and 781, which relate to duties and responsibilities for physician supervision of physician assistants. Grounds for discipline also include:

21.5(1) The physician supervises a physician assistant when the physician does not have sufficient training or experience to supervise a physician assistant in the area of medical practice in which a physician assistant is to be utilized.

21.5(2) A physician supervises more than five physician assistants at the same time.

21.5(3) The physician fails to ensure that the physician assistant is adequately supervised, including being available in person or by telecommunication to respond to the physician assistant.

21.5(4) The physician fails to adequately direct and supervise a physician assistant or fails to comply with the minimum standards of supervision in accordance with this chapter, Iowa Code section 148.13 and chapter 148C, and 481—Chapters 780 through 784.

653—21.6(148,272C) Disciplinary sanction. The board may restrict or rescind a physician's authority to supervise a physician assistant as part of a disciplinary sanction following a contested case proceeding, if the reason for the disciplinary action impacts the ability of the physician to supervise a physician assistant. The board shall notify the board of physician assistants when it takes a disciplinary action against a physician's license that affects the physician's authority to supervise a physician assistant.

653—21.7(148,272C) Communication with physician assistant supervisees. The physician shall notify all physician assistant supervisees within one workday upon receiving disciplinary action from the board or any other change in status that affects the physician's eligibility to supervise a physician assistant.

653—21.8(17A,147,148,272C) Waiver requests. Waiver requests shall be submitted in conformance with 481—Chapter 6.

These rules are intended to implement Iowa Code sections 148C.3 and 272C.3.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 22
“Mandatory Reporting”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 147, 148 and 272C

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 17A, 147, 148 and 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking provides guidance for reporting certain instances that are required by statute. Physicians are required to report judgments, settlements, out-of-state discipline, wrongful acts or omissions by another licensee, child abuse, and hospital discipline to the Board of Medicine within a specified period of time.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There are no costs to the public to comply with this rulemaking. Licensees do not have any costs associated with reporting these items to the Board.

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. Staff provide administrative support to the Board for the decisions the Board is authorized to make pursuant to the Iowa Code, investigate complaints, and assist with disciplinary action when needed. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557.

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

The public, licensees, and employers benefit from this rulemaking because the rules ensure licensees are reporting the information required by statute. With the reporting requirements, the Board is able to ensure public safety and assess issues that might not be filed as a complaint.

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:

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. Licensees do not have any costs associated with reporting these items to the Board.

- Qualitative description of impact:

This rulemaking ensures public safety by requiring licensees to report certain information to the Board, such as acts or omissions in violation of Board rules, loss of privileges to practice, and discipline from another jurisdiction. Without the reporting requirements, the Board may not be informed of incidents that require investigation and discipline.

3. Costs to the State:

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

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. Staff provide administrative support to the Board for the decisions the Board is authorized to make pursuant to the Iowa Code, investigate complaints, and assist with disciplinary action when needed. Staff salaries to support the work of the Board are covered by the fund.

- Anticipated effect on state revenues:

This rulemaking has no anticipated impact on state revenues. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The cost to the Board is minimal since the staff utilized share other duties for implementation of Board rules. Without the reporting requirements, the Board may not be informed of incidents that require investigation and discipline.

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

The Board has not identified a more cost-effective alternative to the mandatory reporting requirements. Iowa Code chapter 272C requires the Board to ensure mandatory reporting of these items.

Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort.

6. Alternative methods considered by the agency:

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

The Board has not identified a more cost-effective alternative to the mandatory reporting requirements. Iowa Code chapter 272C requires the Board to ensure mandatory reporting of these items.

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

The Board has not identified a more cost-effective alternative to the mandatory reporting requirements. Iowa Code chapter 272C requires the Board to ensure mandatory reporting of these items.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of licensing requirements for physicians. While some physicians likely are running a small business of their own, some also work for large corporations and hospitals. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 22 and adopt the following **new** chapter in lieu thereof:

CHAPTER 22
MANDATORY REPORTING

653—22.1(272C) Mandatory reporting—judgments or settlements. Each licensee, including inactive licensees, will report to the board and provide a copy of every adverse judgment and settlement of a claim against the licensee in a malpractice action within 30 days from the date of said judgment or settlement. Failure to report judgments or settlements within the 30-day period is a basis for disciplinary action.

653—22.2(272C) Mandatory reporting—wrongful acts or omissions.

22.2(1) Definitions. For the purposes of this rule, the following definitions apply:

“Knowledge” means any information or evidence of reportable conduct acquired by personal observation, from a reliable or authoritative source, or under circumstances causing the licensee to believe that wrongful acts or omissions may have occurred.

“Reportable conduct” means wrongful acts or omissions that are grounds for license revocation or suspension under these rules or that otherwise constitute negligence, careless acts or omissions that demonstrate a licensee's inability to practice medicine competently, safely, or within the bounds of medical ethics, pursuant to Iowa Code sections 272C.3(2) and 272C.4(6) and 653—Chapter 23.

22.2(2) Reporting requirement. A report shall be filed with the board, within 30 days from the date the licensee acquires knowledge, when a licensee has knowledge that another person licensed by the board may have engaged in reportable conduct. Failure to report is a basis for disciplinary action.

a. The report must contain the name and address of the licensee who may have engaged in the reportable conduct; the date, time, place, and circumstances in which the conduct occurred; and a statement explaining how knowledge of the reportable conduct was acquired.

b. The board makes the final determination of whether or not wrongful acts or omissions have occurred.

c. A physician is not required to report confidential communication obtained from a physician in the course of and as a result of a physician-patient relationship or when a state or federal statute prohibits such disclosure.

d. A licensee will not be civilly liable for filing a report with the board so long as such report is not made with malice.

653—22.3(272C) Mandatory reporting—disciplinary action in another jurisdiction. Each licensee, including inactive licensees, will report to the board, within 30 days of the action, every license revocation, suspension or other disciplinary action taken against the licensee by a professional licensing authority of another state; an agency of the United States government; or any country, territory or other jurisdiction. Failure to report in accordance with this rule is a basis for disciplinary action.

653—22.4(272C) Mandatory reporting—child abuse and dependent adult abuse. Each licensee will report child abuse and dependent adult abuse as required by state and federal law. Knowingly and willfully failing to report child abuse and dependent adult abuse is a basis for disciplinary action.

653—22.5(272C) Mandatory reporting—hospital disciplinary action. Each licensee, including inactive licensees, will file with the board a copy of the disciplinary action or voluntary action and a written report describing any disciplinary action taken by a hospital for reasons relating to the physician's professional competence or conduct that results in a limitation, restriction, suspension, revocation, relinquishment or nonrenewal of the licensee's hospital privileges or any voluntary limitation, restriction, suspension, revocation, relinquishment or nonrenewal of the licensee's hospital privileges to avoid an investigation or other hospital disciplinary action. A licensee is not required to report a limitation, restriction, suspension, revocation, relinquishment or nonrenewal of the licensee's privileges of fewer than 10 days. A licensee is not required to report a voluntary, nondisciplinary limitation or relinquishment of hospital privileges made at the election of the licensee to narrow or change the nature of the licensee's medical practice for reasons not related to competency or conduct. The written report must be filed with the board within 30 days of the date of the action. Failure to file the written report and a copy of the action is a basis for disciplinary action. Reports shall be maintained by the board in accordance with Iowa Code section 272C.6(4).

These rules are intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 23
“Grounds for Discipline”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 272C

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking provides protection to Iowans because it publicly defines required professional standards for physicians. This is important to both the public and the licensee because it creates a shared understanding of what is and is not appropriate for licensees in the state of Iowa. When professional standards are not met, it can subject a licensee to discipline against the licensee’s license. Iowans have the ability to submit a complaint to the licensing board, which can then investigate the allegation. The Board of Medicine has the ability to seek discipline against the licensee for those items outlined, ensuring that the public is protected.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:

While there are no known costs to the public, professional standards of practice are undoubtedly associated with costs to the licensed professional. The rule in this chapter is related to standards of care, so there would be a cost to the practitioner in taking the needed time to review prevailing standards of care in medical journals, etc. The Board is unable to assess a cost related to this specific requirement.

Licensees may also be required to pay a civil penalty fee to satisfy disciplinary action. Disciplinary fines are capped at \$10,000 per public order.

Costs to the agency are for the staff time needed to manage Board activities, which include managing complaints and conducting investigations when a licensee violates a practice standard. The time needed to manage this provision is generally in the form of responding to questions related to complaints and the act of investigating a case. Due to the higher number of complaints associated with this Board than with others, costs specific to managing complaints and investigations are more than other boards.

Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557.

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

This is important to both the public and the licensee because it creates a shared understanding of what is and is not appropriate for licensees in the state of Iowa. When professional standards are not met, it can subject a licensee to discipline against their license. Iowans have the ability to submit a complaint to the licensing board, which can then investigate the allegation. The Board has the ability to seek discipline against the licensee for those items outlined, ensuring that the public is protected.

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:

The Board receives a higher number of complaints than many other boards and issues public discipline in approximately 5 percent of its cases. However, the Board also issues letters of warning or education in 10 to 15 percent of its cases. In 2022, the Board received 660 complaints and issued public discipline. Medicine is a very large profession at approximately 17,000 licensed individuals. The number of complaints filed indicate that there is public support for the work the Board conducts in its investigations. Health is one of the most important aspects of Iowans' lives, and they deserve competent professionals who can provide them with the best care possible.

- Qualitative description of impact:

Establishing minimum requirements and imposing discipline on licensees when requirements are not met ensures safety for the licensee and consumer. Inaction would increase the potential for injury to the public and would leave the public without a method to file a complaint or seek discipline against a licensee who violates the standards of care.

3. Costs to the State:

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

Costs to the agency are for the staff time needed to manage Board activities, which include managing complaints and conducting investigations when a licensee violates a practice standard. The time needed to manage this provision is generally in the form of responding to questions related to complaints and the act of investigating a case. Due to the higher number of complaints associated with this Board than with others, costs specific to managing complaints and investigations are more than other boards.

Staff salaries to support the work of the Board are covered by the fund.

- Anticipated effect on state revenues:

Costs associated with implementing this chapter are paid by individual licensees or establishments, not the State. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

Disciplinary fees collected under this authority go to the General Fund. In 2022, a total of \$0 was paid into the General Fund by disciplinary fees assessed by the Board.

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

The Board receives a higher number of complaints than many other boards and issues public discipline in approximately 5 percent of its cases. However, the Board also issues letters of warning or education in 10 to 15 percent of its cases. In 2022, the Board received 660 complaints and issued public discipline. Medicine is a very large profession at approximately 17,000 licensed individuals.

The number of complaints filed indicate that there is public support for the work the Board conducts in its investigations. Health is one of the most important aspects of Iowans' lives, and they deserve competent professionals that can provide them the best care possible.

Even with the slightly higher costs associated with this Board, access to competent physicians is worth the costs to safeguard Iowans. The Board believes the costs associated with managing the disciplinary process and proceedings is necessary to ensure Iowans have safe practitioners and the public is aware of concerns with a licensee's practice.

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

The Board has not identified a less restrictive alternative to public protection. There could be a consideration of reducing or eliminating professional standards and grounds for discipline, but the Board believes that these requirements are important in order to ensure that Iowans receive health care from competent practitioners.

Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort. The Department is actively pursuing a single licensing platform to assist in standardizing licensing.

6. Alternative methods considered by the agency:

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

The Board has not identified a less restrictive alternative to public protection. There could be a consideration of reducing or eliminating professional standards and grounds for discipline, but the Board believes that these requirements are important in order to ensure that Iowans receive health care from competent practitioners.

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

The Board has not identified a less restrictive alternative to public protection. There could be a consideration of reducing or eliminating professional standards and grounds for discipline, but the Board believes that these requirements are important in order to ensure that Iowans receive health care from competent practitioners.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of practice standards for optometrists. While some physicians likely are running a small business of their own, some also work for large organizations, such as hospital systems. To exempt

small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 23 and adopt the following **new** chapter in lieu thereof:

CHAPTER 23
GROUNDS FOR DISCIPLINE

653—23.1(272C) Grounds for discipline. The board has the authority to impose discipline for any violation of Iowa Code chapter 147, 148, 148E, 148H, 252J, 272C or 272D or the rules promulgated thereunder. The grounds for discipline apply to physicians, acupuncturists and genetic counselors. The board may impose any of the disciplinary sanctions set forth in 481—Chapter 506, including civil penalties in an amount not to exceed \$10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

23.1(1) Violating any of the grounds for the revocation or suspension of a license as listed in Iowa Code section 147.55, 148.6, 148E.8, 148H.7, 272C.10, or 272C.15.

23.1(2) Professional incompetency. Professional incompetency includes but is not limited to any of the following:

- a. Willful or repeated gross malpractice;
- b. Willful or gross negligence;
- c. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the licensee's practice;
- d. A substantial deviation by the licensee from the standards of learning or skill ordinarily possessed and applied by other physicians, acupuncturists or genetic counselors in the state of Iowa acting in the same or similar circumstances;
- e. A failure by a physician, acupuncturist or genetic counselor to exercise in a substantial respect that degree of care that is ordinarily exercised by the average physician, acupuncturist or genetic counselor in the state of Iowa acting in the same or similar circumstances;
- f. A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice in the state of Iowa;
- g. Failure to meet the acceptable and prevailing standard of care when delegating or supervising services provided by another physician, health care practitioner or individual who is collaborating with or acting as an agent, associate, or employee of the physician, acupuncturist or genetic counselor responsible for the patient's care, whether or not injury results.

23.1(3) Practice harmful or detrimental to the public. Practice harmful or detrimental to the public includes but is not limited to:

- a. Failure to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent physician, acupuncturist or genetic counselor acting in the same or similar circumstances.
- b. Practicing without reasonable skill and safety as a result of a mental or physical impairment, chemical abuse or chemical dependency.
- c. For acupuncturists only: prescribing, dispensing or administering any controlled substance or prescription medication for human use or performing any treatment or healing procedure not authorized in Iowa Code chapter 148E or 653—Chapter 17.

23.1(4) Unprofessional conduct. Engaging in unethical or unprofessional conduct includes but is not limited to the committing by a licensee of an act contrary to honesty, justice or good morals,

whether the same is committed in the course of the licensee's practice or otherwise, and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics or rule 653—13.7(147,148,272C), 653—13.20(147,148), 653—17.10(147,148E,272C) or 653—20.4(148H) as interpreted by the board.

23.1(5) Sexual misconduct. Engaging in sexual misconduct includes but is not limited to engaging in conduct set out at 653—subrule 13.7(4) or 13.7(6) as interpreted by the board.

23.1(6) Substance abuse. Substance abuse includes but is not limited to excessive use of alcohol, drugs, narcotics, chemicals or other substances in a manner that may impair a licensee's ability to practice the profession with reasonable skill and safety.

23.1(7) Indiscriminately or promiscuously prescribing, administering or dispensing any drug for other than lawful purpose includes but is not limited to:

- a. Self-prescribing or self-dispensing controlled substances.
- b. Prescribing or dispensing controlled substances to members of the licensee's immediate family.

(1) Prescribing or dispensing controlled substances to members of the licensee's immediate family is allowable for an acute condition or on an emergency basis when the licensee conducts an examination, establishes a medical record, and maintains proper documentation.

(2) Immediate family includes the physician's spouse or domestic partner and either of the physician's, spouse's, or domestic partner's parents, stepparents or grandparents; the physician's natural or adopted children or stepchildren and any child's spouse, domestic partner or children; the siblings of the physician or the physician's spouse or domestic partner and the sibling's spouse or domestic partner; or anyone else living with the physician.

23.1(8) Physical or mental impairment. Physical or mental impairment includes but is not limited to any physical, neurological or mental condition that may impair a licensee's ability to practice the profession with reasonable skill and safety. Being adjudged mentally incompetent by a court of competent jurisdiction automatically suspends a license for the duration of the license unless the board orders otherwise.

23.1(9) Felony criminal conviction. Being convicted of a felony in the courts of this state, another state, the United States, or any country, territory or other jurisdiction, as defined in Iowa Code section 148.6(2) "b." A copy of the record of conviction or plea of guilty or nolo contendere is conclusive evidence of the felony conviction.

23.1(10) Violation of the laws or rules governing the practice of medicine, acupuncture or genetic counseling of this state; another state; the United States; or any country, territory or other jurisdiction. Violation of the laws or rules governing the practice of medicine, acupuncture or genetic counseling includes but is not limited to willful or repeated violation of the provisions of these rules or the provisions of Iowa Code chapter 147, 148, 148E, 148H or 272C or other state or federal laws or rules governing the practice of medicine.

23.1(11) Violation of a lawful order of the board, previously entered by the board in a disciplinary or licensure hearing, or violation of the terms and provisions of a consent agreement or settlement agreement entered into between a licensee and the board.

23.1(12) Violation of an initial agreement or health contract entered into with the Iowa professional health programs (IPHP).

23.1(13) Failure to comply with an evaluation order. Failure to comply with an order of the board requiring a licensee to submit to evaluation under Iowa Code section 148.6(2) "h" or 272C.9(1).

23.1(14) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession includes but is not limited to an intentional perversion of the truth, either orally or in writing, by a physician in the practice of medicine and surgery or osteopathic medicine and surgery, by an acupuncturist, or by a genetic counselor.

23.1(15) Fraud in procuring a license. Fraud in procuring a license includes but is not limited to an intentional perversion of the truth in making application for a license to practice acupuncture,

medicine and surgery, osteopathic medicine and surgery, or genetic counseling in this state and includes false representations of material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or attempting to file or filing with the board any false or forged document submitted with an application for a license in this state.

23.1(16) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes but is not limited to a licensee's having made misleading, deceptive or untrue representations as to the acupuncturist's, physician's or genetic counselor's competency to perform professional services for which the licensee is not qualified to perform by education, training or experience.

23.1(17) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes but is not limited to an action by a licensee in making known to the public information or intention that is false, deceptive, misleading or promoted through fraud or misrepresentation and includes statements that may consist of but are not limited to:

- a. Inflated or unjustified claims that lead to expectations of favorable results;
- b. Self-laudatory claims that imply that the licensee is skilled in a field or specialty of practice for which the licensee is not qualified;
- c. Representations that are likely to cause the average person to misunderstand; or
- d. Extravagant claims or claims of extraordinary skills not recognized by the profession.

23.1(18) Obtaining any fee by fraud or misrepresentation.

23.1(19) Acceptance of remuneration for referral of a patient to other health professionals in violation of the law or medical ethics.

23.1(20) Knowingly submitting a false report of continuing education or failure to submit the required reports of continuing education.

23.1(21) Knowingly aiding, assisting, procuring, or advising a person in the unlawful practice of acupuncture, medicine and surgery, or osteopathic medicine and surgery.

23.1(22) Failure to report disciplinary action. Failure to report a license revocation, suspension or other disciplinary action taken against the licensee by a professional licensing authority of another state; an agency of the United States government; or any country, territory or other jurisdiction within 30 days of the final action by such licensing authority. A stay by an appellate court does not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report will be expunged from the records of the board.

23.1(23) Failure to report voluntary agreements. Failure to report any voluntary agreement to restrict the practice of acupuncture, medicine and surgery, osteopathic medicine and surgery, or genetic counseling entered into with this state; another state; the United States; an agency of the federal government; or any country, territory or other jurisdiction.

23.1(24) Failure to notify the board within 30 days after occurrence of any settlement or adverse judgment of a malpractice claim or action.

23.1(25) Failure to file the reports required by rule 653—22.2(272C) within 30 days concerning wrongful acts or omissions committed by another licensee.

23.1(26) Failure to comply with a valid subpoena issued by the board pursuant to Iowa Code sections 17A.13 and 272C.6, 653—subrule 24.2(6), and 481—Chapter 506.

23.1(27) Failure to submit to a board-ordered mental, physical, clinical competency, or substance abuse evaluation or drug or alcohol screening.

23.1(28) The inappropriate use of a rubber stamp to affix a signature to a prescription. A person who is unable, due to a disability, to make a written signature or mark, however, may substitute in lieu of a signature a rubber stamp that is adopted by the disabled person for all purposes requiring a signature and that is affixed by the disabled person or affixed by another person upon the request of the disabled person and in the presence of the disabled person.

23.1(29) Maintaining any presigned prescription that is intended to be completed and issued at a later time.

23.1(30) Failure to comply with the recommendations issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures, or with the protocols established pursuant to Iowa Code chapter 139A.

23.1(31) Failure by a physician with HIV or HBV who practices in a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by a hospital under Iowa Code section 139A.22(1) or to an expert review panel established by the department of health and human services under Iowa Code section 139A.22(3).

23.1(32) Failure by a physician with HIV or HBV who practices outside a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by the department of health and human services under Iowa Code section 139A.22(3).

23.1(33) Failure by a physician subject to the reporting requirements of subrules 23.1(31) and 23.1(32) to comply with the recommendations of an expert review panel established by the department of health and human services pursuant to Iowa Code section 139A.22(3), with hospital protocols established pursuant to Iowa Code section 139A.22(1), or with health care facility procedures established pursuant to Iowa Code section 139A.22(2).

23.1(34) Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary proceedings initiated under this rule shall follow the procedures set forth in Iowa Code chapter 252J and 653—Chapter 15.

23.1(35) Fraud in the practice. Fraud in the practice includes but is not limited to any misleading, deceptive, untrue or fraudulent representation in the practice of acupuncture, medicine or surgery, or genetic counseling, made orally or in writing, that is contrary to the licensee's legal or equitable duty, trust, or confidence and is deemed by the board to be contrary to good conscience, prejudicial to the public welfare, and potentially injurious to another. Proof of actual injury need not be established.

23.1(36) Improper management of medical records. Improper management of medical records includes but is not limited to failure to maintain timely, accurate, and complete medical records.

23.1(37) Failure to transfer medical records to another physician in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient.

23.1(38) Failure to respond to or comply with a board investigation initiated pursuant to Iowa Code section 272C.3 and rule 653—24.2(17A,147,148,272C).

23.1(39) Failure to comply with the direct billing requirements for anatomic pathology services established in Iowa Code section 147.106.

23.1(40) Failure to submit an additional completed fingerprint card and applicable fee, within 30 days of a request made by board staff, when a previous fingerprint submission has been determined to be unacceptable.

23.1(41) Failure to respond to the board or submit continuing education materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(42) Failure to respond to the board or submit requested mandatory training for identifying and reporting abuse materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(43) Nonpayment of state debt as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 272D and 653—Chapter 12.

23.1(44) Voluntary agreements. The board may take disciplinary action against a physician if that physician has entered into a voluntary agreement to restrict the practice of medicine in another state, district, territory, or country.

a. The board will use the following criteria to determine if a physician has entered into a voluntary agreement within the meaning of Iowa Code section 148.12 and this rule.

(1) The voluntary agreement was signed during or at the conclusion of a disciplinary investigation, or to prevent a matter from proceeding to a disciplinary investigation.

(2) The agreement includes any or all of the following:

1. Education or testing that is beyond the jurisdiction's usual requirement for a license or license renewal.

2. An assignment beyond what is required for license renewal or regular practice (e.g., adoption of a protocol, use of a chaperone, completion of specified continuing education, or completion of a writing assignment).

3. A prohibition or limitation on practice privileges (e.g., a restriction on prescribing or administering controlled substances).

4. Compliance with an educational plan.

5. A requirement that surveys or reviews of patients or patient records be conducted.

6. A practice monitoring requirement.

7. A special notification requirement for a change of address.

8. Payment that is not routinely required of all physicians in that jurisdiction, such as a civil penalty, fine, or reimbursement of any expenses.

9. Any other activity or requirements imposed by the board that are beyond the usual licensure requirements for obtaining, renewing, or reinstating a license in that jurisdiction.

b. A certified copy of the voluntary agreement shall be considered prima facie evidence.

23.1(45) Performing or attempting to perform any surgical or invasive procedure on the wrong patient or at the wrong anatomical site or performing the wrong surgical procedure on a patient.

23.1(46) Violation of the standards of practice for medical directors who delegate and supervise medical aesthetic services performed by nonphysician persons at a medical spa as set out in rule 653—13.8(148,272C).

23.1(47) Failure to provide the board, within 14 days of a request by the board as set out in 653—paragraph 13.8(5) "l," written verification of the education and training of all nonphysician persons who perform medical aesthetic services at a medical spa.

23.1(48) Failure to file with the board a written report and a copy of the hospital disciplinary action within 30 days of any hospital disciplinary action or the licensee's voluntary action to avoid a hospital investigation or hospital disciplinary action as required by rule 653—22.5(272C).

23.1(49) Unethical conduct of acupuncturist. The Code of Ethics (2016) prepared and approved by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) is utilized by the board as guiding principles in the practice of acupuncture in this state. Unethical conduct in the practice of acupuncture includes but is not limited to:

a. Failing to provide patients with the information required in Iowa Code section 148E.6 or providing false information to patients;

b. Disclosing confidential information about a patient without proper authorization; or

c. Abrogating the boundaries of acceptable conduct in the practice of acupuncture established by the profession that the board deems appropriate for ensuring that acupuncturists provide Iowans with safe and healthful care.

This rule is intended to implement Iowa Code chapters 17A, 147, 148, 148E, 148H, 272C and 272D.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 24
“Complaints and Investigations”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 147, 148 and 272C

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 17A, 147, 148 and 272C

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa

Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking is intended to provide guidance on complaint and investigation procedures. The rulemaking ensures that licensees are aware of the investigative process and understand their rights and responsibilities related to the complaint and investigative process. The rulemaking sets forth information such as the process for submitting a complaint, duties of the licensee in reporting the licensee’s own malpractice or disciplinary actions, and duties of the licensee in reporting firsthand knowledge of violations from other licensees. The rulemaking also provides the procedure to issue investigatory subpoenas, initiate the peer review process and require Board of Medicine appearances by the licensee.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:

There is not a direct cost to the licensee to comply with this rulemaking. However, a licensee does have to pay licensing application and renewal fees, which in turn gives the professional licensing boards the ability to hire staff to investigate the complaints. The licensee could also incur costs if the licensee decides to retain counsel to represent the licensee during the investigative process.

The agency bears the cost of staff to review complaints and investigate complaints. The time needed to manage this rulemaking is generally in the form of written and verbal correspondence,

issuing subpoenas, gathering records, conducting interviews and preparing investigative reports. The Board reviews the investigative information at Board meetings. The Board members are paid a per diem for official board duties (\$50 per day) and mileage. Peer reviews require additional costs. An executive officer supports the full scope of work of this Board. Additionally, there are seven full-time medical investigators. Staff salaries to support the work of the Board are covered by the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go to the fund to cover operations of the regulated professional licensing boards.

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

The public and licensees benefit from the proposed rulemaking. The rulemaking ensures that licensees have knowledge of the complaint and investigative processes. This ensures licensees understand their responsibilities and rights surrounding complaints and investigations. The investigative process also benefits the Board because it permits the Board to gather needed information to determine whether a violation of Board rules did occur. In turn, the public benefits because the investigatory process is the primary mechanism the boards have to ensure the public's safety and welfare.

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:

The Board receives approximately 700 complaints per year for which these processes are used to investigate the complaints. The Board receives a higher number of complaints than many other boards and issues public discipline in approximately 5 percent of its cases. However, the Board also issues letters of warning or education in 10 to 15 percent of its cases. In 2022, the Board received 660 complaints and issued public discipline. Medicine is a very large profession at approximately 17,000 licensed individuals. The number of complaints filed indicate that there is public support for the work the Board conducts in its investigations.

- Qualitative description of impact:

The purpose of complaints and investigations is to address allegations against licensees, enable the Board to make informed decisions, and protect the public from unscrupulous practice. Eliminating complaints and investigations would allow acts detrimental to the public to go unchecked, which would ultimately be harmful to the public's safety and welfare. The process proposed by this rulemaking works to allow staff to obtain necessary information and for the Board to then evaluate the extent to which a complaint does or does not violate Board rules. This process is fairly similar across the country for regulated professions.

3. Costs to the State:

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

The Department bears costs to enforce this chapter; however, the costs to support Board staff salaries are paid by the fund. The fund is funded through licensing fees. An executive officer supports the full scope of work of this Board. Additionally, there are seven full-time medical investigators.

- Anticipated effect on state revenues:

This rulemaking has no anticipated impact on state revenues. Staff salaries to support the work of the Board are covered by the fund. Licensing fees go to the fund to cover the operations of the regulated professional licensing boards.

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

The purpose of this rulemaking is to provide a method whereby the public can submit complaints to the Board for violations of Board rules by a licensee. The rulemaking further allows the Board a process to investigate the complaints and determine whether said violation did occur. When there is a violation, licensees are held accountable for the violation to ensure the protection of the public's safety and welfare. Eliminating the Board's ability to receive complaints and conduct investigations would allow acts detrimental to the public to go unchecked and cause harm to the public.

The public and State bear no costs to implement this rulemaking because the Board's costs are funded through the fund. The fund is created through licensing fees paid by the licensees for initial and renewal licenses and is used to cover the operations of the regulated professional licensing boards.

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

The Board's investigative process is largely dictated by statute in Iowa Code chapter 272C. This rulemaking sets forth the mechanisms to implement Iowa Code chapter 272C as required. The majority of the time and costs to implement this rulemaking come from the resources to investigate and the Board's time to review and deliberate on the investigative findings. The Board does utilize cost-effective measures to reduce the costs, such as letter correspondence when available instead of conducting personal interviews. After reviewing similar practices in states across the country, it was found that the investigative process in Iowa is fairly similar to the processes used across the country for regulated and licensed professionals.

6. Alternative methods considered by the agency:

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

Staff held conversations on alternative methods to implement and enforce this rulemaking. After reviewing the processes used in surrounding states, staff found that the complaint and investigative process in Iowa is similar to the processes used across the country to investigate licensed professionals. Due to the state government alignment, this Board is now part of the Department. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort. The Department is actively pursuing a single licensing platform to assist in standardizing licensing.

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

The Board's ultimate goal is ensuring the public's safety and welfare. The purpose of this rulemaking is to allow a method for the public to bring complaints against licensed professionals and allow the Board to investigate complaints. The Board needs the ability to investigate complaints, gather information, and make informed decisions on whether a rule has been violated. Without this process, acts detrimental to the public will go unchecked and ultimately harm the public.

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?

The proposed rulemaking relates to high-stakes public safety concerns that are present whether the business is a small business or a large corporation. The licensees affected by this rulemaking come from a variety of settings. While some licensees could be running a small business, some also work for large hospitals, clinics and retailers. To exempt small businesses from adhering to this rulemaking

would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business to comply with this rulemaking. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 24 and adopt the following **new** chapter in lieu thereof:

CHAPTER 24
COMPLAINTS AND INVESTIGATIONS

653—24.1(17A,147,148,272C) Complaints.

24.1(1) *Form and content of the complaint.* A complaint will be made in the form deemed acceptable by the board. The complaint will contain the following information:

- a. The full name, address and telephone number of the complainant, except in instances in which the identity of the complainant is unknown.
- b. The full name, address and telephone number, if known, of the licensee.
- c. A clear and accurate statement of the facts that apprises the board of the allegations against the licensee.

24.1(2) *Place and time of filing of the complaint.* A written complaint may be delivered in person, by mail or electronically to the board office. The office address is Iowa Board of Medicine, 6200 Park Avenue, Des Moines, Iowa 50321.

24.1(3) *Immunity.* A person is not civilly liable as a result of filing a report or complaint with the board or peer review committee, or for the disclosure to the board or its agents or employees, whether or not pursuant to a subpoena of records, documents, testimony or other forms of information that constitute privileged matter concerning a recipient of health care services or some other person, in connection with proceedings of a peer review committee, or in connection with duties of the board. However, such immunity from civil liability is not applicable if such act is done with malice.

653—24.2(17A,147,148,272C) Processing complaints and investigations.

24.2(1) *Complaint and investigative files.* Board staff shall open a complaint file upon receiving a complaint or other appropriate information or upon a motion of the board. A complaint file becomes an investigative file once an investigation is ordered.

- a. If the board does not have legal jurisdiction over a matter, staff may close the complaint file administratively without investigation or review by the board. All other complaints will be sent to the complaint review committee.
- b. A complaint file will be labeled as such and is not a public record. A complaint file will become part of the licensee's history with the board.
- c. Any time an investigation is ordered, a complaint file will be relabeled as an investigative file. An investigative file is not a public record. The investigative file will become part of the licensee's history with the board and may be shared with another licensing authority upon request.

24.2(2) *Complaint review committee.*

- a. The complaint review committee includes the medical advisor, executive director, general counsel for the board, and chief investigator.
- b. The complaint review committee reviews each complaint the board has received and takes one of the following four actions:
 - (1) Close a complaint file administratively for any of these reasons:
 1. The board does not have legal jurisdiction over the matter;
 2. The case involves a matter that the board is already addressing; or

3. The case is appropriate for referral to the board's Iowa physician health program, and investigation is not warranted.

(2) Recommend to the board's screening committee that the board close the complaint file without investigation.

(3) Request a letter of explanation from the physician, medical records, or both.

(4) Request a full investigation.

c. The complaint review committee uses the following to guide its decision making:

(1) Serious public safety issues include but are not limited to the following:

1. A clear violation of the laws and rules governing the practice of medicine, genetic counseling, or acupuncture, as applicable;

2. Significant investigative history that raises serious concerns about the licensee's ability to practice in a competent and safe manner;

3. Significant investigative history that raises serious concerns that the licensee has engaged in a pattern of unprofessional conduct or disruptive behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff;

4. Serious quality of care cases that include severe patient harm, a pattern of inappropriate treatment, or serious medical errors;

5. Serious criminal conduct;

6. Substance abuse or other impairment that significantly impacts the licensee's ability to practice the licensee's respective practice in a competent and safe manner;

7. Sexual misconduct;

8. Severe unprofessional conduct or disruptive behavior;

9. Disciplinary action by another regulatory authority; or

10. Unlicensed practice of medicine, genetic counseling, or acupuncture.

(2) Less serious public safety issues include but are not limited to the following:

1. Less serious quality of care cases that do not involve serious patient harm and are isolated occurrences rather than a part of a pattern of inappropriate treatment or serious medical errors;

2. A single incident involving a billing dispute;

3. A single incident involving rude behavior or personality conflicts;

4. A single incident of communication problems; or

5. Poor recordkeeping practices that are not repeated or ongoing in nature and do not significantly affect patient care.

d. The board may at any time reopen for review and reconsideration any complaint or investigative file that has been closed administratively.

e. The complaint review committee will indicate high-priority cases when they are assigned for investigation. The committee may provide recommendations to investigators regarding the nature of investigation to be completed. The medical advisor will provide medical advice to the investigators as part of the investigative process.

24.2(3) Screening committee. The screening committee will review the recommendations of the complaint review committee and take one of the following actions:

a. Recommend to the board that the complaint file be closed without investigation.

b. Request a letter of explanation from the physician, medical records, or both.

c. Review the materials acquired pursuant to paragraph 24.2(3) "b" and recommend to the board that the investigative file be closed, with or without issuing an informal letter.

d. Request an investigation for board review.

24.2(4) Board action.

a. The board will review the screening committee's recommendations and take one of the following actions:

(1) Close the complaint file without investigation. The board will notify the complainant and the licensee of the decision.

(2) Close the investigative file that has been partially or fully investigated, with or without issuing an informal letter. The board will notify the complainant and the licensee of the decision.

(3) Request further investigation.

b. The board may reconsider and reopen a closed complaint or investigative file at a later date should it be deemed appropriate.

24.2(5) Investigations.

a. *Complainants.* At the time an investigation is opened, the complainant will be sent a letter with the name of the investigator assigned to the case and the investigator's contact information and a statement encouraging the complainant to submit any further information that would assist the investigator with the case.

(1) The complainant may request a meeting with the investigator prior to the completion of the investigation.

(2) The complainant will be informed of the confidentiality of the investigative information as provided in subrule 24.2(8).

(3) The complainant may contact the chief investigator with questions or concerns about the investigation.

b. *Investigative subpoenas.*

(1) Issuance of an investigative subpoena. The executive director or a designee may, upon the written request of a board investigator or upon the executive director's own initiative, subpoena books, papers, records, and other real evidence necessary for a board investigation.

(2) Request for subpoena. A written request for a subpoena will contain the following:

1. The name and address of the person to whom the subpoena will be directed;

2. A specific description of the books, papers, records or other real evidence requested;

3. An explanation of why the evidence sought to be subpoenaed is necessary for the board to determine whether it should institute a contested case proceeding; and

4. In the case of a subpoena request for mental health records, confirmation that the conditions described in subparagraph 24.2(5) "b"(4) have been satisfied.

(3) Contents of subpoena. Each subpoena will contain the following:

1. The name and address of the person to whom the subpoena is directed;

2. A description of the books, papers, records or other real evidence requested;

3. The date, time and location for production or inspection and copying;

4. The time within which a motion to quash or modify the subpoena must be filed;

5. The signature, address and telephone number of the executive director or designee;

6. The date of issuance; and

7. A return of service attached to the subpoena.

(4) Subpoena for mental health records. A subpoena for mental health records shall meet the requirements of subparagraph 24.2(5) "b"(3). The board shall document the following prior to the issuance of a subpoena for mental health records:

1. The nature of the complaint reasonably justifies the issuance of a subpoena;

2. Adequate safeguards have been established to prevent unauthorized disclosure;

3. An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and

4. An attempt was made to notify the patient and to secure an authorization from the patient for release of the records at issue.

(5) Motion to quash or modify subpoena.

1. Any person who is adversely affected by compliance with the subpoena and desires to challenge the subpoena must file with the board a motion to quash or modify the subpoena within 14 days of service, or before if the time specified is less than 14 days. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

2. Hearing on motion. Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to hold a hearing and issue a decision, or the board may conduct a hearing and issue a decision. Oral argument may be scheduled at the discretion of the administrative law judge or the board. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

3. Appeal of decision on motion. A person who is aggrieved by a ruling of an administrative law judge and who desires to challenge that ruling must appeal the ruling to the board by serving on the board's executive director, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge.

4. Final agency action. If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until either the person is notified that the investigation has been concluded with no formal action or there is a final decision in the contested case.

c. Licensee response. Before a contested case begins, the investigator will attempt to reach the licensee at the licensee's listed address to allow the licensee to respond to the allegations. If the licensee cannot be found there, reasonable efforts to locate the licensee will be made. If the licensee cannot be located, the investigation will proceed without the licensee's response, and the findings will be sent to the board. Contact and response from the licensee can be in writing or through a personal interview.

d. Investigative report. Upon completion of an investigation, the investigator will prepare a report for the board's consideration. The report will set forth the information obtained in the course of the investigation and the response, if any, of the licensee.

e. Board review. The board will review the investigative record, discuss the case, and take one of the following actions:

(1) Close the investigative file without action. The board will notify the complainant and the licensee of the decision. The board may reconsider and reopen a closed complaint or investigative file at a later date should it be deemed appropriate.

(2) Request further investigation, including peer review.

(3) Meet with the licensee. The board or the licensee may request that the licensee appear before the board to discuss a pending investigation. The board has discretion on whether to grant a licensee's request for an appearance. By electing to participate in the appearance, the licensee waives any objection to a board member's both participating in the appearance and later participating as a decision maker in a contested case proceeding on the grounds that:

1. Board members have personally investigated the case, and

2. Board members have combined investigative and adjudicative functions.

If the executive director or director of legal affairs participates in the appearance, the licensee further waives any objection to having the executive director or director of legal affairs assist the board in the contested case proceeding.

(4) Issue an informal letter of warning or education. If the board concludes that there is not probable cause to file disciplinary charges, the board may issue the licensee an informal letter of warning or education. A letter of warning or education is an informal communication between the board and the licensee and is not formal disciplinary action or a public document.

(5) File a statement of charges. If the board determines that there is probable cause for taking formal disciplinary action against a licensee, the board shall file a statement of charges, thereby commencing a contested case proceeding.

Prior to the initiation of formal disciplinary charges in a case involving the supervision of a physician assistant, the board shall forward a copy of the investigative report to the board of physician assistants for its advice and recommendation. The board of physician assistants shall respond within six weeks or sooner if requested by the board of medicine. The board of medicine shall consider the advice and recommendation of the board of physician assistants.

(6) Request a combined statement of charges and settlement agreement. At the board's discretion, the board and the licensee may enter into a combined statement of charges and settlement agreement to resolve a contested case proceeding.

24.2(6) *Licensee-patient privileged communications.* The privilege of confidential communication between the recipient and the provider of health care services do not extend to afford confidentiality to medical records maintained by or on behalf of the subject of an investigation by the board, or records maintained by any public or private agency or organization, which relate to a matter under investigation by the board. No provision of Iowa Code section 622.10, except as it relates to an attorney of the licensee, or the stenographer or confidential clerk of the licensee's attorney, shall be interpreted to restrict access by the board or its staff or agents to information sought in an investigation being conducted by the board.

24.2(7) *Investigation of malpractice lawsuits, judgments and settlements.* The board will review reports received from insurance carriers and licensees involving malpractice lawsuits, adverse judgments, and settlements. The board may choose to investigate such reports in the same manner as is prescribed in these rules for the review and investigation of other complaints to determine whether there is probable cause under applicable statutes or administrative rules for licensee discipline.

24.2(8) *Confidentiality of investigative information.* All investigative information gathered by the board or its employees or agents, including peer reviewers, is confidential and privileged. The information cannot be obtained through discovery, subpoena, or other legal means except by the licensee and the board. This information is not admissible in any judicial or administrative proceeding, except in cases involving licensee discipline. However, the board's statement of charges, settlement agreements, or decisions in disciplinary proceedings are public records.

653—24.3(272C) Peer review. The board may assign any case to peer review for evaluation of the professional services rendered by the licensee and report to the board.

24.3(1) *Registration of peer reviewers.* The board may register peer reviewers by maintaining a list of peer reviewers in the board office. The board will enter into a contract with peer reviewers to provide peer review services.

24.3(2) *Case referral for peer review.* The board or board staff will determine which peer reviewer(s) will review a case and what investigative information is referred to a peer reviewer.

24.3(3) *Board assistance to peer reviewers.* The board may provide investigatory and related services to assist the peer reviewer(s).

24.3(4) *Confidentiality.* Peer reviewers shall observe the confidentiality requirements imposed by Iowa Code section 272C.6(4).

24.3(5) *Liability, defense and indemnity.* Peer reviewers are not liable for acts, omissions or decisions made in connection with service on the peer review committee. However, such immunity from civil liability does not apply if such act is done with malice. Peer reviewers are to be provided a defense by the state for civil lawsuits related to board peer review and will be indemnified for all such judgments or settlements as provided by applicable law and administrative rules.

24.3(6) *Written peer review report.* Peer reviewers will review the information provided by the board and provide a written report to the board.

a. The written report will contain a statement of facts, an opinion of the peer reviewers whether the licensee violated the standard of care, and the rationale supporting the opinion.

b. The written report shall be signed by all peer reviewers concurring in the report.

c. If the peer reviewers find that they are unable to review the case, the investigative information shall be returned to the board.

653—24.4(272C) Order for physical, mental, or clinical competency evaluation. All licensees will undergo a physical, mental, or clinical evaluation as directed by the board. This evaluation may be ordered if there is probable cause of a mental, physical, or behavioral condition, including professional misconduct, disruptive behavior, or substance abuse. The evaluation may include various assessments

for disruptive behavior or neuropsychological, psychiatric, sexual misconduct, or substance abuse evaluations. Clinical competency evaluations can be ordered if there is probable cause of professional incompetence. All evaluation orders and related information are confidential according to Iowa Code section 272C.6(4). The licensee will bear the cost, and orders will be delivered via personal service or certified mail, return receipt requested.

24.4(1) *Content of order.* A board order shall include the following items:

a. Probable cause. A showing by the board that there is probable cause to order the licensee to complete an evaluation.

b. Nature of evaluation or screening. A description of the type of evaluation or screening that the licensee needs to complete.

c. Evaluation facility. The name and address of the examiner or evaluation or treatment or screening facility that the board has identified to perform the evaluation.

d. Scheduling the evaluation. The amount of time in which the licensee must schedule the required evaluation.

e. Completion of the evaluation. The amount of time in which the licensee must complete the evaluation.

f. Board release. A requirement that the licensee sign all necessary releases for the board to communicate with the evaluator or the evaluation or treatment program and to obtain any reports generated by the program.

24.4(2) *Alternatives.* Following issuance of the evaluation order, the licensee may request additional time to schedule or complete the evaluation or to request the board to approve an alternative evaluator or treatment facility. The board will determine whether to grant such a request.

24.4(3) *Objection to order.* A licensee who is the subject of a board evaluation order and who objects to the order may file a request for hearing. The request shall be filed within 14 days of issuance of the evaluation order. A licensee who fails to timely file a request for hearing to object to an evaluation order waives any future objection to the evaluation order in the event formal disciplinary charges are filed for failure to comply with the evaluation order or on any other grounds. The request for hearing shall specifically identify the factual and legal issues upon which the licensee bases the objection. The hearing will be considered a contested case proceeding and will be governed by the provisions of 653—Chapter 25.

24.4(4) *Closed hearing.* Any hearing on an objection to the board order will be closed pursuant to Iowa Code section 272C.6(1).

24.4(5) *Order and reports confidential.* An evaluation order and any subsequent evaluation reports issued in the course of a board investigation are confidential investigative information pursuant to Iowa Code section 272C.6(4). However, all investigative information related to an evaluation order will be provided to the licensee in the event the licensee files an objection under 24.4(3), in order to allow the licensee an opportunity to prepare for hearing.

24.4(6) *Admissibility.* In the event the licensee submits to evaluation and subsequent proceedings are held before the board, all objections will be waived as to the admissibility of the licensee's testimony or evaluation reports on the grounds that they constitute privileged communication. The medical testimony or examination reports will not be used against the licensee in any proceeding other than one relating to licensee discipline by the board.

24.4(7) *Failure to submit.* Failure of a licensee to submit to a board-ordered mental, physical, clinical competency or substance abuse evaluation or alcohol or drug screening constitutes a violation of the rules of the board and is grounds for disciplinary action.

These rules are intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 653—Chapter 26
“Reinstatement After Disciplinary Action”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 17A, 147, 148 and 272C
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 17A

Public Hearing

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

November 5, 2024
9 a.m.

6200 Park Avenue
Des Moines, Iowa
Information on virtual participation will be available on the Department of Inspections, Appeals, and Licensing’s website prior to the hearing.

Public Comment

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

Emily DeRonde
Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue
Des Moines, Iowa 50321
Email: emily.deronde@dia.iowa.gov

Purpose and Summary

This proposed rulemaking provides guidance and the process for reinstatement for licensees who have received disciplinary action from the Board of Medicine. When a licensee has prior disciplinary action from the Board, there are often additional requirements that must be met before a license will be reinstated. These additional requirements help ensure the physicians are competent and safe to practice.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There are no costs to the public to comply with this rulemaking. The licensee incurs the cost of reinstatement and licensing fees.

The cost to the Board to implement and enforce this chapter includes staff time to process the reinstatement applications, answer questions about the process, and gather the necessary documents from licensees. The Board has 6.0 full-time equivalent (FTE) positions for licensing specialists who process license applications and answer applicant and licensee questions. Staff salaries are paid from the Licensing and Regulation Fund established in 2023 Iowa Acts, Senate File 557. Licensing fees go into the fund to cover the costs of the Board regulations.

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

The public and licensees benefit from the proposed rulemaking. Establishing minimum reinstatement requirements ensures that practitioners are competent to practice. Without having an established threshold for reentry into the profession, individuals who are not appropriately rehabilitated could harm the public. The Board believes the cost to license this profession is justified by the benefits achieved because the chapter ensures that Iowans are treated by competent and qualified practitioners.

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:

Medicine is a large profession with approximately 17,000 licensed physicians in Iowa. In 2022, the Board received 660 complaints and issued public discipline in approximately 3 percent of the disciplinary cases. The public discipline may include suspension or revocation of the license. In these instances, the licensee must adhere to the provisions of this chapter to have the license reinstated.

- Qualitative description of impact:

Establishing minimum reinstatement requirements ensures that practitioners are competent to practice. Without having an established threshold for reentry into the profession, individuals who are not appropriately rehabilitated could harm the public. The Board believes the cost to license this profession is justified by the benefits achieved because the chapter ensures that Iowans are treated by competent and qualified practitioners.

3. Costs to the State:

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

The cost to the Board to implement and enforce this rulemaking includes staff time to process the reinstatement applications, answer questions about the process, and gather the necessary documents from licensees. The Board has 6.0 FTE positions for licensing specialists who process license applications and answer applicant and licensee questions. Staff salaries are paid from the fund. Licensing fees go into the fund to cover the costs of the Board regulations.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues. Staff salaries are paid from the fund. Licensing fees go into the fund to cover the costs of the Board regulations.

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

Establishing minimum reinstatement requirements ensures that practitioners are competent to practice. Without having an established threshold for reentry into the profession, individuals who are not appropriately rehabilitated could harm the public. The Board believes the cost to license this profession is justified by the benefits achieved because the chapter ensures that Iowans are treated by competent and qualified practitioners.

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

The Board has not identified any less costly or less intrusive methods for achieving the purpose of this rulemaking. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort.

6. Alternative methods considered by the agency:

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

The Board has not identified any less costly or less intrusive methods for achieving the purpose of this rulemaking. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. These rule edits support this effort.

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

The Board has not identified any less costly or less intrusive methods for achieving the purpose of this rulemaking. The Department's Licensing Division continues to assess and implement opportunities to increase efficiencies and standardize board processes across all professional licensing boards. The updates to this chapter support this effort.

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?

The proposed chapter relates to high-stakes public safety concerns that are present whether the business is a small business or a large organization. The chapter is meant to ensure public safety in terms of practice standards for optometrists. While some physicians likely are running a small business of their own, some also work for large organizations, such as hospital systems. To exempt small businesses from adhering to this chapter would jeopardize any member of the public who sought services from that small business. The risk to the public is greater than the potential harm or cost to the small business. Additionally, if a licensee subject to this chapter is a small business and has identified a rule that is overly burdensome and the goals of which could be achieved in a manner that would reduce the impact on the small business, the licensee could utilize the Department's established waiver process.

Text of Proposed Rulemaking

ITEM 1. Rescind 653—Chapter 26 and adopt the following **new** chapter in lieu thereof:

CHAPTER 26 REINSTATEMENT AFTER DISCIPLINARY ACTION

653—26.1(17A) Reinstatement. Any person whose license has not been permanently suspended or revoked by the board may apply to the board for reinstatement in accordance with the terms and conditions of the order of revocation or suspension.

26.1(1) If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur, or if the license was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the board order or the date of voluntary surrender.

26.1(2) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the board an application for the reinstatement of the respondent's license. Such application will be docketed in the original case in which the license was revoked, suspended, or relinquished. All proceedings upon the petition for reinstatement are subject to the same rules of procedure as other cases before the board.

26.1(3) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the revocation or suspension of the respondent's license no longer exists and that it will be in the public interest for the license to be reinstated. The burden of proof to establish such facts is on the respondent.

26.1(4) At the board's discretion, the board and the licensee may agree to enter into a reinstatement order by agreement, in lieu of a formal reinstatement hearing before the board.

26.1(5) A reinstatement order must be based upon the affirmative vote of a quorum of the board. The reinstatement order is public information pursuant to 481—Chapter 506.

26.1(6) A physician seeking reinstatement under this rule whose license became inactive during the period of suspension or revocation is also required to complete the reactivation process set forth in 653—9.13(147,148) or 653—9.14(147,148).

This rule is intended to implement Iowa Code chapters 17A, 147, 148, and 272C.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 5
“Maternal Deaths”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Not applicable
State or federal law(s) implemented by the rulemaking: Iowa Code section 135.40

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

Public Comment

Any interested person may submit written 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:

Joe Campos
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Email: joe.campos@hhs.iowa.gov

Purpose and Summary

The purpose of this chapter is to allow for the procurement and timely confidential review of maternal death and birth records, which inform death prevention recommendations and efforts.

The State Mortality Review Committee (2024 Iowa Acts, Senate File 2385) prompted the centralization of death review teams. Chapter 5 is proposed to be rescinded and centralized with 641—Chapters 90, 91 and 92. Procurement and review will continue to occur as part of this centralized chapter and as a subcommittee of the State Mortality Review Committee.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
Because procurement and review will continue to occur as part of a consolidated chapter and as a subcommittee of the State Mortality Review Committee, no impacts were identified.
 - Qualitative description of impact:

Because procurement and review will continue to occur as part of a consolidated chapter and as a subcommittee of the State Mortality Review Committee, no impacts were identified.

3. Costs to the State:

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

Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 5**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 12

“Approval of Confirmatory Laboratories for Private Sector Drug-Free Workplace Testing”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 730.5(7)“f”

State or federal law(s) implemented by the rulemaking: Iowa Code section 730.5(7)“f”

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this rulemaking is to allow the Department to approve confirmatory laboratories so that non-Substance Abuse and Mental Health Services Administration (SAMHSA)-certified laboratories are conducting confirmatory drug testing in accordance with state and federal regulations.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Laboratories applying with the Department will bear the costs.
 - Classes of persons that will benefit from the proposed rulemaking:
Laboratories that are not approved by the SAMHSA will benefit.
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:
There are five laboratories that are approved by the Department. Each must submit a \$300 renewal fee each year to maintain the certification.
 - Qualitative description of impact:
This rulemaking allows laboratories that are not certified by SAMHSA to conduct confirmatory drug testing in Iowa in conformance with state and federal laws.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
There are administrative costs to approve the certification applications each year.

- Anticipated effect on state revenues:
None.

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

Not having the chapter would reduce the number of laboratories that can perform confirmatory drug testing for employers in Iowa.

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

None.

6. Alternative methods considered by the agency:

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

None.

- 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 rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 12 and adopt the following **new** chapter in lieu thereof:

CHAPTER 12 APPROVAL OF CONFIRMATORY LABORATORIES FOR PRIVATE SECTOR DRUG-FREE WORKPLACE TESTING

641—12.1(730) Definitions. For the purpose of these rules, the following definitions apply:

“*Alcohol or drug testing*” means analysis of a sample for the purpose of detecting the presence or absence of alcohol or other drugs, or their metabolites, in the sample tested.

“*CLIA*” means the Clinical Laboratory Improvement Amendments of 1988.

“*CMS*” means the Centers for Medicare and Medicaid Services.

“*GC/MS*” means gas chromatography/mass spectrometry.

“*Laboratory*” means a facility inside or outside the state of Iowa approved to conduct confirmatory testing of samples for the detection of alcohol or other drugs, or their metabolites.

“Sample,” for the purpose of these rules, means the substances determined by the department to be samples from the human body capable of accurately and reliably revealing the presence of alcohol or other drugs, or their metabolites, including hair, urine, saliva, breath, and blood.

“SHL” means the state hygienic laboratory.

“Specimen” means a part taken from a sample to determine the character of the whole sample.

641—12.2(730) Powers and duties. The department is responsible for the following actions:

12.2(1) Processing applications from laboratories requesting approval to conduct confirmatory testing pursuant to Iowa Code section 730.5(7) “f.”

12.2(2) Developing an application package.

a. The department will make an application package available to all laboratories requesting approval to conduct confirmatory testing for alcohol or other drugs, or their metabolites.

b. The package will contain application procedures, a standardized application form and a self-inspection questionnaire.

c. The self-inspection questionnaire will assist the department in assessing the quality of a laboratory’s performance as a confirmatory testing laboratory. This questionnaire will comprise the major but not the sole objective criteria used during the initial on-site inspection conducted by the SHL.

d. The package will be available from the department upon request.

12.2(3) Reviewing each application submitted and determining the adequacy for approval.

12.2(4) Designating the SHL to conduct an on-site inspection of each approved confirmatory laboratory at least once every two years. Inspection may be waived by the director if the laboratory has been inspected and accredited for forensic drug testing by the College of American Pathologists, or if the laboratory has been inspected and certified, licensed, or approved to conduct confirmatory testing by another state whose requirements are at least equal to Iowa’s.

12.2(5) Maintaining and providing upon request an updated list of all approved confirmatory laboratories.

12.2(6) Providing written notice of approval and assigning an expiration date.

641—12.3(730) Application procedures and requirements. Laboratories desiring to conduct confirmatory testing for Iowa’s employers shall apply to the department for approval. Each laboratory requesting Iowa approval to conduct confirmatory testing shall provide the following to the department:

12.3(1) A completed laboratory survey checklist on a form provided by the department.

12.3(2) A completed self-inspection questionnaire provided by the department.

12.3(3) Proof of enrollment in a recognized proficiency testing program. Recognized programs include those approved by CMS.

12.3(4) Acceptable performance over a 12-month period in all appropriate areas of proficiency testing for alcohol or other drugs, or their metabolites, shall be documented and maintained on an ongoing basis. Acceptable performance is as follows:

a. Initial approval shall require at least 80 percent accuracy in the last two graded proficiency test cycles with no false positive results.

b. Renewal shall require at least 80 percent accuracy each year on graded proficiency surveys with no false positive results.

641—12.4(730) Requirements of laboratory personnel involved in confirmatory testing for alcohol or other drugs, or their metabolites.

12.4(1) The laboratory director shall be a pathologist or doctoral level individual who qualifies as a clinical laboratory director under CLIA regulations.

12.4(2) Supervisors of analysts shall possess at least a bachelor of science degree in chemistry, medical technology, or comparable education and two years of analytical alcohol or drug testing

experience. Supervisors must also have training in the theory and practice of laboratory procedures and an understanding of quality control concepts. Annual verification of the supervisor's skills must be documented by the laboratory director.

12.4(3) Analysts shall possess the necessary training and skills for assigned tasks. These individuals shall possess at least two years of college education in the physical or biological sciences. At a minimum, analysts shall be graduates of a medical laboratory technician program that is recognized by the department or have at least two years of college with a minimum of nine semester hours in chemistry.

12.4(4) Laboratory directors, supervisors and analysts involved in alcohol or drug testing shall annually complete at least one in-service continuing education program related to alcohol or drug testing. Continuing education programs include formal training programs where continuing education units are awarded, informal in-house training programs, and relevant correspondence courses. Dates, titles and subject matter for each completed course shall be documented and the information shall be available for review.

12.4(5) The following information about each of the laboratory staff involved in alcohol or drug testing shall be retained for two years from date of termination and shall be available for review:

- a. Résumé of training and experience.
- b. Certificate or license.
- c. Job description.

641—12.5(730) Quality assurance program and procedure manual requirements. All approved confirmatory laboratories shall have a written quality assurance program and a procedure manual that encompasses all aspects of the alcohol or drug testing process.

12.5(1) Approved laboratories shall have written procedures for performing alcohol or drug testing that shall include the following:

- a. Sample acquisition.
- b. Chain of custody.
- c. Sample and report security.
- d. Test performance.
- e. Reporting of results.
- f. Confidentiality.

12.5(2) The quality assurance program and procedure manuals shall be available for review during any on-site inspection.

12.5(3) Approved laboratories shall review their performance in each of the above areas every 12 months.

12.5(4) Approved laboratories are responsible for developing the criteria necessary to establish and maintain an effective quality assurance program for confirmatory testing of alcohol or other drugs, or their metabolites.

641—12.6(730) Analytical quality control. The number and position of control specimens tested within a batch and the number of calibrators used for each batch of specimens shall be consistent with generally accepted laboratory practice for the methodology used to conduct confirmatory testing.

12.6(1) Positive and negative controls shall be used in testing each batch of specimens.

12.6(2) Procedures shall be implemented and documented to ensure that carryover from a positive specimen does not contaminate other subsequent specimens in that batch.

12.6(3) Approved laboratories shall develop criteria for the detection and rejection of adulterated samples.

641—12.7(730) Sample security and confidentiality of test results. Samples and reports must never be left unattended or unsecured.

12.7(1) Complete chain of custody documentation shall be maintained for each sample from the time of collection from the employee or prospective employee to the time the sample is discarded. Each time the sample is handled or transferred, the individual receiving the sample, the time and date of transfer, and the recipient or destination of the sample shall be documented.

12.7(2) If the first portion of the sample yielded a confirmed positive test result, the laboratory shall store the second portion of that sample until receipt of a confirmed negative test result or for a period of at least 45 calendar days following the completion of the initial confirmatory testing. Urine and blood samples shall be retained in secure storage at freezing temperatures.

12.7(3) All samples for which a negative test result was reported shall be disposed of within five working days after issuance of the negative test result report.

641—12.8(730) Confirmatory testing.

12.8(1) Reports for alcohol shall be confirmed by gas chromatography, or a test that is recognized by the department as an equivalent test before being reported as positive (or negative).

12.8(2) Reports for drugs or their metabolites, other than alcohol, shall not be issued in the absence of confirmation by GC/MS or a scientifically equivalent test approved by the department.

12.8(3) Complete chain of custody procedures shall be used for referred samples.

641—12.9(730) Documentation of the confirmatory testing process. The following documents shall be retained for at least two years and, if requested, made available for inspection.

12.9(1) Chain of custody documentation shall be maintained for each sample tested with the identification of the sample, the person(s) handling and testing the sample, the storage of the sample, and the eventual disposal of the sample.

12.9(2) Documents regarding the following: analytical information for each batch assayed, instrument identification, calibration records, identification of reagent lot numbers and expiration dates, quality control results, and any other pertinent information.

12.9(3) Copies of proficiency testing results for ongoing monitoring and evaluation of laboratory performance. Approved confirmatory laboratories inspected by the SHL shall submit copies of proficiency testing results to the SHL or shall ensure that proficiency testing programs submit copies of proficiency testing results directly to the SHL on their behalf.

12.9(4) Current procedure manuals must be maintained for all procedures.

12.9(5) An annual review of manuals shall be performed and documented. Alterations and additions to procedures shall be incorporated into manuals and approved by the laboratory director before implementation.

641—12.10(730) Reporting of confirmed positive test results to the medical review officer.

12.10(1) Each report shall identify the alcohol or other drugs, or their metabolites, being tested with the results of positive/negative or detected/nondetected clearly recorded.

12.10(2) Approved confirmatory laboratories shall have available a written summary of the established sensitivity levels used for the confirmatory tests conducted for alcohol or other drugs, or their metabolites. However, this information need not be issued with each report.

12.10(3) Approved confirmatory laboratories shall have written procedures for making both written and telephone reports to the medical review officer.

12.10(4) All test results must be reviewed and signed by the laboratory director, or a qualified designee, before being reported to the medical review officer.

641—12.11(730) Reporting requirements to department. Pursuant to Iowa Code section 730.5(16), approved confirmatory laboratories shall file a report with the department by March 1 of each year. The report shall include the number of positive and negative drug or alcohol test results for the previous calendar year for the following if available to the laboratory:

1. Employees who work in non-safety-sensitive positions,
2. Employees who work in safety-sensitive positions,

3. Employees during and after completion of drug or alcohol rehabilitation,
4. Employees as a consequence of reasonable suspicion drug or alcohol testing,
5. Prospective employees,
6. As a consequence of federal law or regulation, or by law enforcement,
7. As a consequence of accident investigation in the workplace,
8. The types of drugs which were found in the positive drug tests,
9. All significant available demographic factors relating to the positive test pool, and
10. Total number of positive and negative drug or alcohol test results for the previous calendar year for all employees and prospective employees who were tested.

641—12.12(730) Approval, renewal, and inspection fees. At the time of initial application and each year thereafter, laboratories shall remit to the department a fee in an amount sufficient to reimburse the department for expenses incurred in administering the confirmatory laboratory approval program. All fees shall be made payable to the department and are as follows:

12.12(1) *Approval.* An administration fee of \$600 is required for new applications, including applicants seeking approval through reciprocity.

12.12(2) *Renewal.* An administration fee of \$300 is required to renew laboratory approval.

12.12(3) *Inspections by the SHL.* Reimbursement for actual on-site inspection and related expenses shall be assessed to each laboratory after the completion of each inspection. Expenses related to the on-site inspection shall be reimbursed to the SHL. These expenses shall reflect the actual cost incurred for personnel time and travel expenses consistent with state of Iowa travel reimbursement policies and procedures. These expenses shall also include the time necessary for SHL inspection staff to:

- a. Review the application and related laboratory materials in preparation for the on-site inspection,
- b. Generate the written laboratory report regarding inspection findings,
- c. Conduct postinspection follow-up activities, if any, and
- d. Review proficiency test results on an ongoing basis.

641—12.13(730) Renewal. Laboratories wishing to continue confirmatory testing for alcohol or other drugs, or their metabolites, in Iowa must renew their certification annually. The request for renewal shall include the following:

1. Name and address of laboratory.
2. Renewal fee.
3. Information that reflects any changes that occurred during the current approval period.
4. Copy of supporting documents if the laboratory is accredited for forensic drug testing by the College of American Pathologists, or if it is certified, licensed, or approved through reciprocity.

641—12.14(730) Reciprocity.

12.14(1) Confirmatory laboratories certified, licensed, or approved by another state to conduct testing for alcohol or other drugs, or their metabolites, may request Iowa approval through reciprocity by:

- a. Completing and submitting the department's application package, and
- b. Including a copy of their current certificate, license, or approval document from the state whose requirements are at least equal to Iowa's.

12.14(2) Laboratories approved through reciprocity that lose their certification, license or approval from another state shall notify the department within five working days.

641—12.15(730) Changes during approval periods. The following changes that occur during an approval period shall be submitted to the department within five working days from the date the change took place:

1. Change in laboratory director.

2. Change of address.
3. Change in supervisor.
4. Change in confirmation procedures.
5. Change in proficiency testing program.
6. Addition or subtraction of alcohol or other drugs, or their metabolites, being tested.
7. Change of ownership.
8. Loss of accreditation for forensic drug testing by the College of American Pathologists.

641—12.16(730) Enforcement. Upon a determination of noncompliance by the director that these rules have been violated, the director may immediately move to suspend, modify, or revoke any approval issued under these rules.

641—12.17(730) Denial, suspension, modification or revocation of approval. Any one of the following can result in denial, suspension, modification or revocation of approval. Failure of the confirmatory laboratory to:

1. Remain in compliance with the requirements of these rules.
2. Provide required documentation, including documentation of laboratory personnel and proficiency test results.
3. Maintain confidentiality.
4. Meet proficiency testing criteria.
5. Provide correct information.
6. Satisfactorily complete the two most recent and relevant graded proficiency test reports from a recognized proficiency testing program (for initial approval).
7. Correctly represent facts on a self-inspection questionnaire or other application documents.
8. Pass an on-site inspection conducted by the College of American Pathologists for forensic drug testing, or by another state whose requirements are at least equal to Iowa's, or by the SHL.

641—12.18(730) Restoration of approval. A confirmatory laboratory whose approval has been suspended, modified, or revoked may be reinstated within 90 days following the receipt of the following:

1. Documentation of actions that correct the reasons for suspension, modification, or revocation.
2. Documentation of a successful on-site inspection, if necessary, conducted by the College of American Pathologists for forensic drug testing, or by another state whose requirements are at least equal to Iowa's, or by the SHL.

641—12.19(730) Appeals process.

12.19(1) *Denial, suspension, modification, or revocation.* The department will send written notice of denial, suspension, modification, or revocation by certified mail, return receipt requested, pursuant to 441—Chapter 16. The adverse action will become effective 30 days after receipt of the notice unless the applicant, within 90 days, gives written notice to the department requesting a hearing. In that event, the notice will be deemed to be suspended.

12.19(2) *Contested cases.* The procedures for contested cases as set out in Iowa Code chapter 17A and the rules adopted by the department in 441—Chapter 7 will be followed in all cases where proper notice has been made to the department of the intent to formally contest any denial, suspension, modification, or revocation of approval.

641—12.20(730) Complaints.

12.20(1) The department will accept complaints of alleged problems relating to confirmatory laboratory procedures. The information shall state in as specific a manner as possible the basis for the complaint. The complaint shall be presented to the department in writing, in person or by telephone.

12.20(2) Within 20 working days of the receipt of the complaint, the department will communicate with the laboratory director for initial evaluation of the specific matters alleged in the complaint. The complainant will be informed of the results of the action taken by the department.

These rules are intended to implement Iowa Code section 730.5.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 20
“Community Water Fluoridation Grant Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Not applicable
State or federal law(s) implemented by the rulemaking: Iowa Code section 135.11

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

Currently, this chapter outlines parameters for providing grants to fluoride-deficient public water supplies to assist these communities in implementing water fluoridation. The chapter is proposed to be rescinded.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
Because the substance of this chapter will remain present in program policy and any future contracts, no impacts were identified.
 - Qualitative description of impact:
Because the substance of this chapter will remain present in program policy and any future contracts, no impacts were identified.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 20**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 50
“Oral Health”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Not applicable

State or federal law(s) implemented by the rulemaking: Iowa Code sections 135.14 and 135.15

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

These rules were intended to define the responsibilities of the Dental Director and the Oral Health Bureau. The chapter is proposed to be rescinded.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
Not applicable.
 - Qualitative description of impact:
Rulemaking authority for this chapter is not explicit in the Iowa Code. This chapter is being rescinded. Because the Department has established program priorities, policies, plans, and leadership, implementation will continue to occur in absence of administrative rules.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
Not applicable.
 - Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 50.**

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 51
“Dental Screening”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.17

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.17

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines the requirements and processes for ensuring children entering kindergarten and ninth grade submit proof of a dental screening to their school and the subsequent audit of screening certificates. The intended benefit is to improve the oral health of Iowa’s children through prevention, education, care coordination and referral for treatment.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Parents with children who require dental screening or their health insurance provider will bear the costs unless there is a financial hardship and the school or I-Smile public health program provides gap-filling screening.
 - Classes of persons that will benefit from the proposed rulemaking:
School-age children will benefit.
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:
During school year 2022-2023, 20 percent of children entering kindergarten and 14 percent of children entering ninth grade who were screened were found to require dental care (including those needing urgent care). In school year 2021-2022, 16 percent of children entering kindergarten and 13

percent of children entering ninth grade who were screened were found to require dental care (including those needing urgent care).

- Qualitative description of impact:

Dental screenings play an important role in the oral health of Iowa children. Dental screening facilitates early detection and treatment of dental disease, and oral health is a critical component of school and learning readiness.

3. Costs to the State:

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

The Department incurs personnel costs to support the execution of the procedures described in this chapter.

- Anticipated effect on state revenues:

No impact was identified.

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

The absence of these procedures could lead to unidentified dental disease, which can lead to behavioral and learning problems, as well as school absence. The statewide I-Smile network assists with gap-filling screening and referral assistance.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

The Department supports dental screenings in accordance with the Iowa Code. This chapter clarifies specific procedures, but only within the scope and as defined in the Iowa Code. The Department feels this is necessary to protect the dental health of children in Iowa.

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

This chapter implements dental screenings as mandated by the Iowa Code.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 51 and adopt the following **new** chapter in lieu thereof:

CHAPTER 51 DENTAL SCREENING

641—51.1(135) Definitions.

“Admitting official” means the superintendent of schools or the superintendent’s designated representative if a public school; if an accredited nonpublic school, the governing official of the school.

“Applicant” means any person seeking first-time enrollment in kindergarten or ninth grade in a public or accredited nonpublic elementary school or high school in Iowa.

“Dental hygienist” means a person licensed to practice as a dental hygienist.

“Dentist” means a person licensed to practice as a dentist.

“Electronic signature” means a confidential personalized digital key, code, or number that is used for secure electronic data transmission and that identifies and authenticates the signatory.

“Elementary school” means kindergarten through grade six in an Iowa school district or accredited nonpublic school.

“Gum infection” means that gum (gingival) tissue is red, bleeding, or swollen.

“High school” means grades 9 through 12 in an Iowa school district or accredited nonpublic school.

“Injury” means soft tissue laceration or a broken or dislodged tooth.

“I-Smile” means the department program designed to increase access to dental care for children and to ensure a dental home.

“I-Smile coordinator” means a designated dental hygienist who is employed by or under contract with a local public health agency to administer the I-Smile dental home program.

“Local board of health” means a county, city, or district board of health as defined in Iowa Code section 137.102.

“Needs dental care” means that tooth decay or a white spot lesion is suspected in one or more teeth or that gum infection is suspected.

“Needs urgent dental care” means that obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

“No obvious problems” means a child’s hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

“Nurse” means a person licensed to practice as a registered nurse or advanced registered nurse practitioner.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery.

“Physician assistant” means a person licensed to practice as a physician assistant.

“Recorder” means a dentist, dental hygienist, physician, physician assistant, or nurse who is authorized to record screening information and sign the Certificate of Dental Screening form.

“Severe infection” means excessive bleeding, swelling, or pus discharge; or an abscess.

“Signature” means an original signature, or authorized use of stamped signature, or electronic signature of a dentist, dental hygienist, physician, physician assistant, or nurse.

“Tooth decay” means a visible cavity or hole in a tooth with brown or black coloration, or a retained root.

“White spot lesion” means a demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. A white spot lesion is considered an early indicator of tooth decay, especially in primary teeth.

641—51.2(135) Persons included. The dental screening requirements specified in this chapter apply to all persons seeking first-time enrollment in kindergarten or ninth grade in a public or accredited nonpublic elementary school or high school in Iowa.

641—51.3(135) Persons excluded. Exclusions to these rules are permitted on an individual basis for religious and financial hardship reasons. Applicants approved for a religious or financial hardship exemption shall submit to the admitting official a valid department certificate of dental screening exemption.

51.3(1) Religious exemption. A religious exemption may be granted to an applicant if the dental screening conflicts with a genuine and sincere religious belief.

a. The certificate of dental screening exemption for religious reasons shall attest that the dental screening conflicts with a genuine and sincere religious belief and that the belief is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to dental screenings.

b. The certificate of dental screening exemption for religious reasons shall be signed and dated by the applicant or, if the applicant is a minor, by the parent or guardian.

c. To be valid, the certificate of dental screening exemption for religious reasons shall be the department certificate or a form approved in writing by the department.

51.3(2) Financial hardship exemption. A financial hardship exemption may be granted to an applicant who is unduly burdened by the cost of a dental screening.

a. The certificate of dental screening exemption for financial hardship reasons shall attest that dental screening would cause a genuine financial burden to the applicant.

b. The certificate of dental screening exemption for financial hardship reasons shall be signed and dated by a dentist, dental hygienist, physician, physician assistant, or nurse.

c. The certificate of dental screening exemption for financial hardship reasons shall include the provider type and the provider's name, business address, and telephone number.

d. To be valid, the certificate of dental screening exemption for financial hardship reasons shall be the department certificate or a form approved in writing by the department.

51.3(3) A faxed copy, photocopy, or electronic copy of the valid certificate of dental screening exemption is acceptable.

641—51.4(135) Dental screening components.

51.4(1) A dental screening is a visual assessment and is noninvasive and nondiagnostic.

51.4(2) Dental instrumentation is not needed for a dental screening.

51.4(3) A dental screening can identify obvious or suspected oral health conditions that need or that might need examination by a dentist.

51.4(4) The dental screening shall include the following steps:

a. Visual inspection of the soft tissues, including the lips, cheeks, gums, tongue, floor of mouth, and roof of mouth, to assess infection or injury.

b. Visual inspection of all tooth surfaces to assess tooth decay, white spot lesions, or injury.

c. Documentation of the screening and treatment needs according to rule 641—51.8(135).

641—51.5(135) Dental screening providers.

51.5(1) Elementary school. A dental screening for elementary school enrollment shall be performed by a licensed dentist, a licensed dental hygienist, a licensed physician, a licensed physician assistant, or a licensed nurse.

51.5(2) High school. A dental screening for high school enrollment shall be provided by a licensed dentist or a licensed dental hygienist.

641—51.6(135) Time line for valid dental screening.

51.6(1) Elementary school. To be valid, a minimum of one dental screening shall be performed on an applicant no earlier than three years of age but no later than four months after the enrollment date.

51.6(2) High school. To be valid, a minimum of one dental screening shall be performed on an applicant no earlier than one year prior to the enrollment date and no later than four months after the enrollment date.

51.6(3) A dental screening may also be deemed valid by the department if the department determines that the applicant has substantially complied with the dental screening requirements.

641—51.7(135) Proof of dental screening. The applicant or, if a minor, the parent or guardian of a child enrolled in elementary school or high school shall submit a valid department certificate of dental screening to the admitting official of the school district or accredited nonpublic elementary school in which the applicant wishes to enroll.

51.7(1) To be valid, the certificate of dental screening shall be the department certificate or a form approved in writing by the department.

a. The Certificate of Dental Screening form is available on the department's website or by calling the department.

b. The certificate of dental screening shall include all information required by rule 641—51.8(135).

c. The certificate of dental screening may also be deemed valid by the department if the department determines that the information on the certificate substantially complies with the dental screening requirements.

51.7(2) A faxed copy, photocopy, or electronic copy of the valid certificate of dental screening is acceptable.

641—51.8(135) Dental screening documentation.

51.8(1) *Student information.* A person authorized to perform a dental screening required by this chapter shall record the following student information or ensure that such information is recorded on the certificate of dental screening provided or approved in writing by the department in cooperation with the department of education:

- a.* Name (first and last); and
- b.* Birth date.

51.8(2) *Screening information.* A person authorized to perform a dental screening required by this chapter shall record the following screening information on the certificate of dental screening provided or approved in writing by the department in cooperation with the department of education:

- a.* Date of dental screening;
- b.* Treatment needs (no obvious problems, needs dental care, needs urgent dental care);
- c.* Provider type;
- d.* Provider name and telephone number; and
- e.* Provider or recorder signature and credentials.

641—51.9(135) Ensuring dental screening services. Each public and accredited nonpublic school, in collaboration with the department, shall ensure that the parent or guardian of a student enrolled in the school has complied with the dental screening requirement. Parents or guardians of students who do not have a valid certificate of dental screening shall be provided with community dental screening referral resources, including contact information for the I-Smile coordinator, the department, or a dental society.

641—51.10(135) Records. It shall be the duty of the admitting official of an elementary school or a high school to ensure that a valid certificate of dental screening or certificate of dental screening exemption is on file for each child enrolled.

51.10(1) The admitting official shall ensure that all certificates of dental screening are properly completed according to rule 641—51.7(135).

51.10(2) The admitting official shall ensure that all certificates of dental screening exemption are properly completed according to subrules 51.3(1) and 51.3(2).

51.10(3) The admitting official shall keep the certificates of dental screening or certificates of dental screening exemption on file at the school in which the applicant is enrolled and assist the applicant or the applicant's parent or guardian.

51.10(4) The local board of health or its designee, the department of education, and the department or its designee shall have the right to have access to the certificates of dental screening and certificates of dental screening exemption of students enrolled in elementary schools and high schools.

641—51.11(135) Reporting.

51.11(1) It shall be the duty of each local board of health or its designee to audit the certificates of dental screening and certificates of dental screening exemption in the schools within the local board's jurisdiction to determine compliance with Iowa Code section 135.17.

51.11(2) By May 31 annually, each local board of health shall furnish the department with evidence for the preceding school year that each child enrolled in any public or accredited nonpublic school within the local board's jurisdiction met the dental screening requirement.

51.11(3) The evidence shall be in the form of a report that includes:

- a. Name of school,
- b. Enrollments by grade,
- c. The number of valid certificates of dental screening by grade,
- d. The number of valid certificates for religious exemptions by grade, and
- e. The number of valid certificates for financial hardship exemptions by grade.

641—51.12(135) Release of dental screening information.

51.12(1) *Between a dentist, dental hygienist, physician, physician assistant, or nurse, and the elementary school or high school that the child attends.* A dentist, dental hygienist, physician, physician assistant, or nurse shall disclose a student's dental screening information, including the student's name and date of birth; the name of the student's parent or guardian; the month, day and year of the screening; and the screening results and treatment needs to an elementary school or a high school upon written or verbal request from the elementary school or high school. Written or verbal permission from a student or the student's parent or guardian is not required to release this information to an elementary school or a high school.

51.12(2) *Among dentists, dental hygienists, physicians, physician assistants, or nurses.* Dental screening information, including the student's name, date of birth, name of parent or guardian, the month, day and year of the screening, and the screening results and treatment needs shall be provided by one dentist, dental hygienist, physician, physician assistant, or nurse to another health care provider without written or verbal permission from the student or the student's parent or guardian.

641—51.13(135) Referral requirements. Parents or guardians of students who need dental care or need urgent dental care shall be referred to the parent's or guardian's dentist of choice. Students without a dentist or who have difficulty accessing dental care shall be referred to a local I-Smile coordinator or local public health agency for assistance with completion of dental care. This assistance may include locating dentists, scheduling appointments, and identifying payment sources.

641—51.14(135) Provider training. For the purpose of quality assurance and consistency, the department will make training and training materials available for dental screening providers.

These rules are intended to implement Iowa Code section 135.17.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 52
“Vision Screening”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.39D

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.39D

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The intended benefit of this chapter is to improve the eye health and vision of Iowa’s children. The child vision screening program establishes a comprehensive vision evaluation effort to facilitate early detection and referral for treatment of visual impairment in order to reduce vision impairment in children.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Parents with children who require vision screening or their health insurance provider will bear the cost.
 - Classes of persons that will benefit from the proposed rulemaking:
School-age children will benefit.
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:
One in 4 school-aged children and 1 in 20 preschool-aged children has a vision problem. If undetected, some vision problems, such as amblyopia, can lead to permanent vision loss. If detected and treated early, nearly 50 percent of all vision problems can be prevented. In addition, nearly 80 percent of all learning during a child’s first 12 years is through vision, also during the time when

literacy development is most important. Seventy-four percent of children with behavioral concerns fail at least one vision test. Eighty-six percent of children (approximately 166,155 in Iowa) will not receive a comprehensive eye exam prior to entering school.

- Qualitative description of impact:

Vision screenings play an important role in the eye health and vision of Iowa children. These rules facilitate the early detection, prevention and treatment of visual impairment. Eye health and vision are critical to learning readiness and success in school.

3. Costs to the State:

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

The Department incurs personnel costs to support the execution of the procedures described in this chapter.

- Anticipated effect on state revenues:

No impact was identified.

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

The rules outlined in Chapter 52 help to ensure preschool-aged and young school-aged children receive a vision screening, proper follow-up, diagnosis, and treatment if needed during the most impactful years for visual development. If Chapter 52 did not exist, a significantly higher number of children would not receive a vision screening during the time when the potential for further vision impairment could be prevented. This would lead to an increase in preventable visual impairment.

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

A less costly method has not been identified to achieve the purpose of this chapter.

6. Alternative methods considered by the agency:

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

The Department supports vision screening in accordance with the Iowa Code. This chapter clarifies specific procedures, but only within the scope and as defined in the Iowa Code. The Department feels this is necessary to protect the eye health and vision of Iowa's children.

- 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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 52 and adopt the following new chapter in lieu thereof:

CHAPTER 52
VISION SCREENING

641—52.1(135) Definitions.

“Advanced registered nurse practitioner” or *“ARNP”* means the same as defined in rule 655—7.1(17A,124,147,152).

“Autorefractor” means a method of vision screening involving skiascopy methods or wave-front technology to evaluate the refractive error of each eye. Depending on the autorefractor being used, this method allows for immediate results interpreted by the operator or the instrument as a pass or fail.

“Community-based organization” means a public or private nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community and that provides educational or related services to individuals in the community that include utilizing approved age-appropriate, acceptable child vision screening tests approved by the department.

“Comprehensive eye examination” means a clinical diagnostic assessment performed by an optometrist or ophthalmologist to assess a person’s level of vision and to detect any abnormality or diseases.

“Elementary school” means an Iowa public or accredited nonpublic school that a kindergarten or third grade student would attend.

“Iowa KidSight” means a joint project of the lions clubs of Iowa and the university of Iowa, department of ophthalmology and visual sciences, dedicated to enhancing the early detection and treatment of vision impairments in Iowa’s young children (target population six months of age through kindergarten age) through screening and public education.

“IRIS” means the immunization registry information system as established in 641—Chapter 7.

“Online vision screening” means a vision screening test administered from the Internet to a child to assess vision and includes vision test results and recommendations.

“Ophthalmologist” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148 and board-certified in ophthalmology as a specialist in medical and surgical eye problems.

“Optometrist” means a person licensed to practice optometry pursuant to Iowa Code chapter 154.

“Photoscreening” means a method of vision screening employing an automated technique that uses the red reflex of the eye to screen for eye problems and produces immediate readable results and a timely report of the results thereafter.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148.

“Physician assistant” means a person licensed to practice as a physician assistant pursuant to Iowa Code chapter 148C.

“Potential vision impairment” means that a child’s vision appears to be compromised and there is reason for the child to be seen by an ophthalmologist or optometrist.

“Student vision card” means a card distributed by the Iowa optometric association to all schools in Iowa pursuant to Iowa Code section 280.7A. The student vision card recommends children receive a complete eye health examination.

“Vision screening” means an eye testing program that is age- and developmentally appropriate and that assesses visual acuity or other risk factors contributing to refractive errors and other conditions.

641—52.2(135) Persons included and persons excluded.

52.2(1) The child vision screening requirements specified in this chapter apply to all persons seeking first-time enrollment in kindergarten and third grade in a public or accredited nonpublic elementary school in Iowa.

52.2(2) Persons shall be included or excluded as established in Iowa Code section 135.39D.

641—52.3(135) Child vision screening components.

52.3(1) The requirement for a child vision screening may be satisfied pursuant to Iowa Code section 135.39D.

52.3(2) All vision screening methods, including emerging vision screening technologies, shall be age-appropriate and will be approved by the department. A list of acceptable child vision screening tests will be reviewed and updated annually by the department and will be listed on the department's website.

641—52.4(135) Time line for valid vision screening.

52.4(1) *Kindergarten.* To be valid, a minimum of one child vision screening shall be performed on a child no earlier than one year prior to the date of the child's enrollment in kindergarten and no later than six months after the date of the child's enrollment in kindergarten.

52.4(2) *Grade three.* To be valid, a minimum of one child vision screening shall be performed on a child no earlier than one year prior to the date of the child's enrollment in the third grade and no later than six months after the date of the child's enrollment in the third grade.

52.4(3) *Substantial compliance.* A child vision screening may also be deemed valid by the department if the department determines the child has substantially complied with the child vision screening requirements.

641—52.5(135) Proof of child vision screening.

52.5(1) The parent or guardian of a child enrolled in kindergarten or third grade shall ensure that evidence of a child vision screening is submitted to the school district or accredited nonpublic elementary school in which the child is enrolled either electronically through IRIS pursuant to subrule 52.5(2) or in hard copy or electronic form pursuant to subrule 52.5(3).

52.5(2) If the child's vision screening results were electronically submitted to IRIS, the parent or guardian may notify the school district or accredited nonpublic elementary school of such submission to satisfy the requirement for evidence of a child vision screening.

52.5(3) If evidence of the child vision screening is not electronically submitted to IRIS, the parent or guardian shall provide evidence of the child vision screening in hard copy or electronic form directly to the school. Hard copy or electronic evidence of the vision screening shall include the child's first name, last name, date of birth and ZIP code; evidence of the vision screening including the date of screening, left eye results, right eye results, vision screening result of "pass" or "fail," and designation of "yes" or "no" for referral made; and the name of the provider who performed the vision screening.

52.5(4) Submission of a faxed copy, photocopy, or electronic copy of the child vision screening results is acceptable.

52.5(5) If a parent or guardian chooses for a child to receive a comprehensive eye examination completed by an ophthalmologist or optometrist in lieu of a vision screening, the parent or guardian may submit a completed student vision card to satisfy the requirement of this rule.

641—52.6(135) Child vision screening reporting.

52.6(1) A person authorized to perform a child vision screening required by this chapter shall report results of the child vision screening to the department.

a. An ophthalmologist or optometrist shall report the results in written form, either electronically or by hard copy, to the parent or guardian to be forwarded to the department via the school or shall report the results via IRIS if available.

b. A pediatrician's or family practice physician's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization or an ARNP or physician assistant shall report the results in written form, either electronically or by hard copy, to the parent or guardian to be forwarded to the department via the school or shall report the results via IRIS if available.

c. Results from an online vision screening administered from the Internet shall be generated in an electronic or hard-copy report to the parent or guardian to be forwarded to the department via the school or the results shall be reported via IRIS if available.

d. The results of photoscreening vision screening, including those performed by Iowa KidSight, shall be reported to the parent or guardian in written form, either electronically or by hard copy, to be forwarded to the department via the school or shall be reported via IRIS if available.

52.6(2) The department will collect and maintain results of the vision screenings submitted electronically, via hard copy or through IRIS.

641—52.7(135) School requirements.

52.7(1) Each public and accredited nonpublic elementary school, in collaboration with the department, shall provide the parents or guardians of students enrolled in the school with vision screening referral resources prior to enrollment or during the enrollment period.

52.7(2) Each public and accredited nonpublic elementary school shall provide to parents or guardians of students for whom evidence of a child vision screening is not submitted community eye health referral resources, including but not limited to contact information for the local public health department, maternal and child health agency, Iowa KidSight, the department, or an optometric or ophthalmology society.

52.7(3) Each public and accredited nonpublic elementary school shall arrange for the following to be forwarded to the department:

a. Child vision screening results or comprehensive eye examination results provided by parents or guardians;

b. A list of students whose parents or guardians indicate that the students' results were reported through IRIS; and

c. Any other evidence of vision screening or comprehensive eye examination provided to the school.

641—52.8(135) Iowa's child vision screening database module and follow-up. The department may develop and maintain a statewide child vision screening database module in IRIS to collect and maintain child vision screening results, to ensure students receive the required vision screening, and to monitor eye health.

52.8(1) The database module will consist of vision screening information, including identifying and demographic data.

52.8(2) Database module reporting will comply with rule 641—52.6(135).

52.8(3) Unauthorized uses of database module. The database module information shall not be used to:

a. Market services to students or nonstudents;

b. Assist in bill collection services; or

c. Locate or identify students or nonstudents for any purpose other than those expressly provided in this rule.

52.8(4) Confidentiality of database module information. Child vision screening information, including identifying and demographic data maintained in the database module, is confidential and may not be disclosed except under the following limited circumstances:

a. The department may release information from the database module to the following:

(1) The person who received the child vision screening or the parent or guardian of the person who received the child vision screening;

(2) Users of the database module that complete an agreement with the department that specifies the conditions under which the database module can be accessed and that have been issued an organization code and username by the department;

(3) Persons or entities requesting child vision screening data in an aggregate form that does not identify an individual either directly or indirectly;

(4) Agencies that complete an agreement with the department which specifies conditions for access to database module information and how that information will be used;

(5) A representative of a state or federal agency, or an entity bound by that state or federal agency, to the extent the information is necessary to perform a legally authorized function of the agency or the department. The state or federal agency is subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa; or

(6) Licensed health care providers, agencies, and other persons involved with vision screenings, eye examinations, follow-up services, and intervention services as necessary to administer this chapter.

b. Approved database module users shall not release child vision screening data except to the person who received the child vision screening; the parent or guardian of the person who received the child vision screening; health records staff of schools; medical, optometry, ophthalmology or health care providers providing continuity of care; and other approved users of the database module.

641—52.9(135) Referral requirements.

52.9(1) If a vision screening identifies a potential vision impairment in a child, the person who performed the vision screening shall, if the person is not an ophthalmologist or optometrist, refer the child to an ophthalmologist or optometrist for a comprehensive eye examination.

52.9(2) Persons performing vision screenings shall contact parents or guardians of children identified as having potential vision impairment based on the results of a vision screening required pursuant to this chapter or a comprehensive eye examination required pursuant to subrule 52.9(1) in order to provide information on obtaining necessary vision correction.

These rules are intended to implement Iowa Code section 135.39D.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 55
“Brain Injury Advisory Council”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 2024 Iowa Acts, Senate File 2385
State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this rulemaking is to rescind a chapter for a council that was eliminated by 2024 legislation.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
There is no specific benefit of the rulemaking other than complying with state law.
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:
This rulemaking rescinds and reserves one chapter.
 - Qualitative description of impact:
The work of the Brain Injury Advisory Council will continue through the Council on Health and Human Services.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
No costs are associated with the rulemaking.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues.

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

Leaving the chapter in place would be inappropriate because the Brain Injury Advisory Council will no longer exist under Iowa law.

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

None.

6. Alternative methods considered by the agency:

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

None.

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

The rulemaking is both appropriate and required by law.

Small Business Impact

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 55**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 67
“Blood Lead Testing”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.102
State or federal law(s) implemented by the rulemaking: Iowa Code section 135.105D and 2008 Iowa Acts, Senate File 2111

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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 (HHS) no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

These proposed rules are intended to help ensure that all Iowa children receive at least one blood lead screening prior to age six.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are minimal costs incurred by the public since blood lead testing is covered by most insurance plans.
 - Classes of persons that will benefit from the proposed rulemaking:
Children under the age of six will benefit.
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:
For school year 2021-2022, HHS received data from 683 schools representing 39,956 students. Of those, 80 percent matched HHS’s database, meaning that 80 percent of students from participating schools had at least one blood lead test prior to the age of six. Among the 38,312 children born in Iowa in 2016, 98.6 percent were tested at least once prior to their sixth birthday in 2022.
 - Qualitative description of impact:

Lead in the blood of children can cause serious health problems such as damage to the brain and nervous system, slowed growth and development, learning and behavior problems, hearing and speech problems, and irritability (sources: [cdc.gov](https://www.cdc.gov) and [mayoclinic.org](https://www.mayoclinic.org))

3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
 - There are costs of approximately \$25,000 for salary and fringe benefits for 0.25 full-time equivalent (FTE) position assigned to coordinate implementation.
 - There are costs of approximately \$20,500 for contractor and state FTE position time for technical support from the Department of Management Division of Information Technology.
 - There are costs related to staff time at schools for implementation; however, there is no estimate for costs associated with this work.
- Anticipated effect on state revenues:

There is no anticipated impact on state revenues.

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

If this chapter did not exist, the HHS would need to rely on alternative mechanisms and measures to demonstrate the rate of children who receive at least one blood lead screening before age six in compliance with Iowa Code section 135.105D. The HHS would not be able to identify and educate parents of children enrolled in kindergarten who have not received a blood lead test about the serious health problems associated with exposure to lead.

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

There could be amendments to Iowa Code section 135.105D(3) to enable the Department of Education, rather than the individual schools, to provide the enrollment data to HHS. This could reduce the administrative burden on school staff time to achieve the purpose.

6. Alternative methods considered by the agency:

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

The agency has considered coordinating with the Department of Education to streamline the sharing of enrollment data with HHS and reduce the administrative burden on individual schools.
- Reasons why alternative methods were rejected in favor of the proposed rulemaking:

The language of Iowa Code section 135.105D(3) was determined to require the collection of enrollment data directly from individual schools.

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?

There are no impacts on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 67 and adopt the following **new** chapter in lieu thereof:

CHAPTER 67
BLOOD LEAD TESTING

641—67.1(135) Definitions. For purposes of this chapter, the following definitions apply:

“*Applicant*” means any person seeking first-time enrollment in kindergarten in a public or accredited nonpublic elementary school in Iowa.

“*Transfer student*” means an applicant from any school outside Iowa who is seeking enrollment in kindergarten in a school in Iowa.

641—67.2(135) Persons included. The blood lead testing requirement specified in this chapter applies to all applicants and transfer students as defined in this chapter.

641—67.3(135) Persons excluded. Exclusions to these rules are permitted on an individual basis for religious reasons and for children determined by the department to be at very low risk for elevated blood lead levels. The parent or guardian of an applicant or transfer student approved for a religious exemption or an exemption for very low risk shall submit to the board of directors of each school district and the authorities in charge of each nonpublic school a valid department certificate of blood lead testing exemption.

641—67.4(135) Records. Within the constraints of the privacy rights of the parents or guardians and students, the local board of health, the department of education, and the department or its designee have the right to access the department’s determination that a child has received a blood lead test and the certificates of blood lead testing exemption of children enrolled in kindergarten.

These rules are intended to implement Iowa Code chapter 135.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 68
“Control of Lead-Based Paint Hazards”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.102

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.102

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The provisions of this chapter are applicable in jurisdictions in which a local board of public health has adopted this chapter for the purpose of requiring control of lead-based paint hazards where a child has been identified with an elevated blood lead level. Nothing in this chapter shall be construed as requiring a local board to adopt this chapter as a model regulation.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Children who live or stay in areas where there is hazardous lead-based paint, a dust-lead hazard, or a soil-lead hazard will benefit.
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:
At last count, there were approximately 60 local jurisdictions that had adopted the model regulation.
 - Qualitative description of impact:
This chapter serves as a model regulation for local boards of public health to use for lead hazard remediation in instances in which a child is confirmed as lead poisoned.
3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
There are no costs to any agency for implementation of these rules; they merely serve as a model should any local boards of health choose to adopt them.
 - Anticipated effect on state revenues:
There is no impact on state revenues.
4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:
Rulemaking is required by Iowa Code chapter 135.
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:
None.
 - Reasons why alternative methods were rejected in favor of the proposed rulemaking:
Rulemaking is required by Iowa Code chapter 135.

Small Business Impact

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

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

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

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 68 and adopt the following **new** chapter in lieu thereof:

CHAPTER 68 CONTROL OF LEAD-BASED PAINT HAZARDS

641—68.1(135) Definitions.

“*Certified elevated blood lead (EBL) inspector/risk assessor*” or “*inspector*” means a person who has met the requirements of rule 641—70.5(135) for certification or interim certification and who has been certified by the department.

“*Chewable surface*” means an interior or exterior surface painted with lead-based paint that a young child can mouth or chew.

“*Child-occupied facility*” means a building, or portion of a building, constructed prior to 1978, visited by the same child under the age of six years on at least two different days within any week

(Sunday through Saturday period, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours).

"Clearance testing" means an activity conducted following interim controls, lead abatement, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation to determine that the hazard reduction activities are complete. Clearance testing includes a visual assessment, the collection and analysis of environmental samples, the interpretation of sampling results, and the preparation of a report.

"Deteriorated paint" means any interior or exterior paint or other coating that is cracking, flaking, chipping, peeling, or chalking, or any paint or coating located on an interior or exterior surface that is otherwise damaged or separated from the substrate of a building component.

"Dripline" means the area within three feet surrounding the perimeter of a building.

"Dust-lead hazard" means surface dust in residential dwellings or child-occupied facilities that contains a mass-per-area concentration of lead greater than or equal to 40 micrograms per square foot on floors, 250 micrograms per square foot on interior windowsills, and 400 micrograms per square foot on window troughs based on wipe samples. A dust-lead hazard is present in a residential dwelling or child-occupied facility when the weighted arithmetic mean lead loading for all single-surface or composite samples of floors and interior windowsills is greater than or equal to 40 micrograms per square foot on floors, 250 micrograms per square foot on interior windowsills, and 400 micrograms per square foot on window troughs based on wipe samples. A dust-lead hazard is present on floors, interior windowsills, or window troughs in an unsampled residential dwelling in a multifamily dwelling if a dust-lead hazard is present on floors, interior windowsills, or window troughs, respectively, in at least one sampled residential unit on the property. A dust-lead hazard is present on floors, interior windowsills, or window troughs in an unsampled common area in a multifamily dwelling if a dust-lead hazard is present on floors, interior windowsills, or window troughs, respectively, in at least one sampled common area in the same common area group on the property. If dust samples are not taken, it may be assumed that surfaces in rooms with hazardous lead-based paint or where renovation, remodeling, or repainting has occurred recently are dust-lead hazards.

"Elevated blood lead" or *"EBL"* means one venous blood level greater than or equal to 20 micrograms per deciliter or at least two venous blood levels of 15 to 19 micrograms per deciliter.

"Elevated blood lead child" or *"EBL child"* means any child who has had one venous blood lead level greater than or equal to 20 micrograms per deciliter or at least two venous blood lead levels of 15 to 19 micrograms per deciliter.

"Elevated blood lead inspection" or *"EBL inspection"* means an inspection to determine the sources of lead exposure for an EBL child and the provision within ten working days of a written report explaining the results of the investigation to the property owner and occupant of the residential dwelling or child-occupied facility being inspected and to the parents of the EBL child. An inspector shall not determine that a residential dwelling is free of lead-based paint as a result of an EBL inspection.

"Friction surface" means an interior or exterior surface that is subject to abrasion or friction, including but not limited to certain window, floor, and stair surfaces.

"Hazardous lead-based paint" means lead-based paint that is present on a friction surface where there is evidence of abrasion or where the dust-lead level on the nearest horizontal surface underneath the friction surface (e.g., the windowsill or floor) is equal to or greater than the dust-lead hazard level, lead-based paint that is present on an impact surface that is damaged or otherwise deteriorated from impact, lead-based paint that is present on a chewable surface, or any other deteriorated lead-based paint in any residential building or child-occupied facility or on the exterior of a residential building or child-occupied facility.

"Impact surface" means an interior or exterior surface that is subject to damage by repeated sudden force such as certain parts of doorframes.

"Lead-based paint" means any paint or other surface coatings that contain lead equal to or in excess of 1.0 milligram of lead per square centimeter or more than 0.5 percent by weight. Lead-based

paint is present on any surface that is tested and found to contain lead equal to or in excess of 1.0 milligram per square centimeter or more than 0.5 percent by weight and on any surface like a surface tested in the same room equivalent that has a similar painting history and that is found to be lead-based paint.

“Lead-based paint hazard” means hazardous lead-based paint, a dust-lead hazard, or a soil-lead hazard.

“Local board” means the local board of health as authorized by Iowa Code chapter 137.

“Mid-yard” means an area of a residential yard approximately midway between the dripline of a residential building and the nearest property boundary or between the driplines of a residential building and another building on the same property.

“Occupant” means any person living, sleeping, cooking or eating in, or having any actual possession of, a dwelling or dwelling unit.

“Owner” means any person who, alone or jointly with others (1) has legal title to any dwelling, with or without accompanying actual possession thereof, or (2) has charge, care or control of any dwelling by acting as the agent of the owner or as the executor, administrator, trustee, or guardian of the estate of the owner.

“Paint-lead hazard” means the presence of hazardous lead-based paint in a residential dwelling or a child-occupied facility.

“Play area” means an area of frequent soil contact by children of less than six years of age as indicated by but not limited to factors including the following: the presence of play equipment, toys, or other children’s possessions; observations of play patterns; or information provided by parents, residents, caregivers, or property owners.

“Residential building” means a building containing one or more residential dwellings.

“Residential dwelling” means (1) a detached single-family dwelling unit, including the surrounding yard, attached structures such as porches and stoops, and detached buildings and structures, including but not limited to garages, farm buildings, and fences; or (2) a single-family dwelling unit in a structure that contains more than one separate residential dwelling unit, that is used or occupied, or intended to be used or occupied, in whole or part, as the home or residence of one or more persons.

“Retaliation” means harassment, termination of the tenancy, discontinuation of utilities or other services, and any other action taken against the lessee.

“Soil-lead hazard” means bare soil on residential real property or on the property of a child-occupied facility that contains total lead greater than or equal to 400 parts per million for the dripline, mid-yard, and play areas. A soil-lead hazard is present in a dripline, mid-yard, or play area when the soil-lead concentration from a composite sample of bare soil is greater than or equal to 400 parts per million. If soil samples are not taken, it may be assumed that bare soil within three feet of the foundation of a garage or other structure built prior to 1978 is a soil-lead hazard.

641—68.2(135) EBL inspections required. The local board will appoint a certified inspector to conduct EBL inspections in residential dwellings and child-occupied facilities where an EBL child lives, visits, or has recently lived. All owners and occupants shall allow access to the residential dwellings and child-occupied facilities that the certified inspector desires to inspect.

641—68.3(135) Refusal of admittance. If the inspector appointed by the local board is refused entry to a property, then the inspector may make a complaint under oath to any magistrate of the county. The magistrate may issue a warrant directing the owner or occupant to allow the inspector to conduct an EBL inspection and directing a peace officer to accompany the inspector during the EBL inspection/risk assessment.

641—68.4(135) Lead hazard reduction required.

68.4(1) When the certified inspector appointed by the local board determines that hazardous lead-based paint, a dust-lead hazard, or a soil-lead hazard is present in a residential dwelling unit or child-occupied facility where an EBL child lives, frequently visits, or has recently resided, the inspector shall issue a written notice to the owner within two weeks of the inspection and receipt of any laboratory results. The written notice shall require the owner to complete lead hazard reduction in a time period determined by the inspector. If the occupant who occupies the residential dwelling at the time that this written notice is issued vacates the residential dwelling, the residential dwelling shall not be leased or occupied by any other person until the inspector issues a written notice that the lead hazard reduction has been completed.

68.4(2) The owner of any residential dwelling or child-occupied facility that has been determined to contain hazardous lead-based paint, a soil-lead hazard, or a dust-lead hazard shall correct these hazards within the time period allowed by the inspector in the written notice. The following methods shall be used for lead hazard reduction. These methods do not require the services of a lead abatement contractor certified in accordance with rule 641—70.5(135). However, other local, state, or federal regulations may require the use of a contractor who has completed an eight-hour lead-safe work practices course or a lead abatement contractor or lead abatement worker certified in accordance with rule 641—70.5(135).

a. On a surface that contains hazardous lead-based paint, but is not chewable and does not have evidence of impact or friction, the lead-based paint hazard shall be reduced by removing all loose and deteriorated paint from the surface, preparing the surface for repainting, and repainting the surface with a lead-free coating.

b. On a surface that contains hazardous lead-based paint and is chewable or has evidence of impact or friction, the lead-based paint hazard shall be reduced by treating the surface one inch back from the edge or corner through one of the following methods:

(1) All lead-based paint on the treatment area shall be removed to the bare substrate. The surface shall be prepared for repainting and repainted with a lead-free coating.

(2) The treatment area shall be covered with a permanently affixed lead-free material such as plastic, wood, or vinyl. Carpet may be used on floors and stair treads.

c. Dust-lead hazards shall be reduced by thoroughly cleaning the affected surface.

d. Soil-lead hazards shall be reduced by planting grass or groundcover, applying sod, or covering the affected area with six inches of bark, gravel, or other material.

e. Lead hazard reduction shall be conducted using lead-safe work practices to protect the safety of the occupants and workers. Occupants shall not enter the work area while work is underway. The following are prohibited methods of lead hazard reduction:

(1) Open-flame burning or torching of lead-based paint.

(2) Machine sanding or grinding or abrasive blasting or sandblasting of lead-based paint unless used with high-efficiency particulate air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at 99.97 percent or greater efficiency.

(3) Uncontained water blasting of lead-based paint.

(4) Dry scraping or dry sanding of lead-based paint except in conjunction with the use of a heat gun or around electrical outlets.

(5) Operating a heat gun at a temperature above 1,100 degrees Fahrenheit.

68.4(3) The inspector shall inspect all areas identified as hazards after lead hazard reduction is complete. The inspector may conduct clearance testing pursuant to 641—Chapter 70 to ensure that no dust-lead hazards exist after the work is complete. Within two weeks of verifying that all lead hazard reduction has been completed as required, the inspector shall issue a written notice to the owner and occupant stating that the lead hazard reduction has been completed and that the repaired surfaces must be maintained in good condition.

641—68.5(135) Retaliation prohibited.

68.5(1) The lessor of a dwelling, the employees of the lessor, and agents or persons acting on behalf of the lessor shall not retaliate against lessees of residential dwellings and child-occupied facilities whose occupants or visitors have been tested for lead poisoning and shall not discourage the occupants or visitors from being tested for lead poisoning.

68.5(2) An action taken against the lessee is not considered retaliation if it is supported by reasonable cause unrelated to the testing of an occupant for lead poisoning or if it is shown to have occurred as a result of an accident or mistake and not to be the intentional act of the lessor of a dwelling, the employees of the lessor, or agents or persons acting on behalf of the lessor.

641—68.6(135) Enforcement. The inspector appointed by the local board will have the duty and responsibility of enforcing this chapter.

68.6(1) Penalties are as provided in Iowa Code section 137.21.

68.6(2) Upon failure of any person to correct a hazard identified through this chapter in the time specified by the inspector appointed by the local board, the local board may direct or cause the correction of said hazards. All expenses incurred thereby may be recovered by suit in the name of the local board, or the local board may certify the amount of the expenses, together with a description of the property, to the county treasurer, who will enter the same into the tax roll as costs for removing a lead hazard, and the amounts will be collected as other taxes.

641—68.7(135) Hearings. In the event any person is aggrieved by any order of the inspector, the person may appeal to the local board in writing within ten days of the date of such order. The appeal shall state the reasons for requesting the order to be rescinded or modified. The local board will review the action of the inspector. The local board will order compliance with the order or may, with cause, modify or withdraw the order. Any order of the local board may be appealed within ten days to the district court for the county in which the local board is located.

641—68.8(135) Variances. The inspector may determine that a chewable surface that would otherwise be identified as a hazard by this chapter is not causing or does not have reasonable potential to cause lead exposure and is not required to be corrected through lead hazard reduction. The inspector shall document the reason for this determination in the inspection report. However, the inspector shall not, under any circumstances, determine that any other surface meeting the definition of hazardous lead-based paint does not need to be corrected through lead hazard reduction.

641—68.9(135) Injunction. Nothing in this chapter prevents a local board from pursuing injunctive relief or other relief as allowed by law.

641—68.10(135) Effective date. This chapter will be in effect in a jurisdiction after a local board adopts it.

These rules are intended to implement Iowa Code section 135.102.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 71
“Emergency Information System on Pesticides for Use by
Health Care Providers During Medical Emergencies”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Not applicable
State or federal law(s) implemented by the rulemaking: Not applicable

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This chapter was intended to establish an emergency information system for pesticides that Iowa health care providers are able to access 24 hours per day, seven days per week, in order to gain access to emergency treatment information for the emergency care of a real-time human exposure to a pesticide.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans in general will benefit.
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:
This rulemaking rescinds a chapter from the Iowa Administrative Code.
 - Qualitative description of impact:
None.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
None.

- Anticipated effect on state revenues:
None.

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

Leaving the chapter in place is not authorized by the Iowa Code and adds to the volume of administrative rules. Rescinding it eliminates unnecessary regulation.

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

No. Rescinding the rule is the proper course of action.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
None.
- 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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 71**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 72
“Childhood Lead Poisoning Prevention Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.102

State or federal law(s) implemented by the rulemaking: Iowa Code sections 135.100 through 135.105 and 135.105B

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed rulemaking is to implement the grant program pursuant to Iowa Code section 135.103 and to set forth the standards and program requirements of the grant program pursuant to Iowa Code section 135.103.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowa children and families will benefit.
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:
There are 18 approved lead poisoning prevention grant programs in Iowa. The 18 programs provide services in 48 counties. In the remaining 51 counties, the Department is responsible for ensuring program services are provided.
 - Qualitative description of impact:
The rulemaking sets forth the qualifications and process for local boards of health to apply for an approved childhood lead poisoning prevention grant program.
3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
Administrative support and contracted funds to local programs and costs associated with implementation in the 51 counties not served by a local program:
 1. \$260,000 in State funds contracted to local programs.
 2. \$300,000 for 3.35 full-time equivalent (FTE) (Salary and Fringe) for 2 Community Health Consultant (CHC), 1 Statistical Research Analyst 2 (SRA2), 1 Clerk Specialist, and 1 Information Technology Specialist 5 (ITS5) from a combination of state and federal grant funds.
- Anticipated effect on state revenues:
None.
- 4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:
Inaction would mean there is no guidance for local childhood lead poisoning prevention programs to apply or maintain local programs, which means the Department would need to hire more staff to cover the entire state, or, if not, and there is total inaction, the result would be children being lead poisoned with no intervention.
- 5. Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:
Most of the rule language comes from the Iowa Code. Other information could be shared on the Department's website. Nevertheless, the Iowa Code says the Department "shall" promulgate rules. This is likely because when the law was originally promulgated, the Department did not have a website and administrative rules were the primary way in which agencies shared information with the public.
- 6. Alternative methods considered by the agency:
 - Description of any alternative methods that were seriously considered by the agency:
None.
 - 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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 72 and adopt the following **new** chapter in lieu thereof:

CHAPTER 72
CHILDHOOD LEAD POISONING
PREVENTION PROGRAM

641—72.1(135) Definitions.

“Approved program” means a program that meets the requirements of Iowa Code section 135.104 and has been approved by the department.

“Local board” means a county, district, or city board of health.

641—72.2(135) Approved programs.

72.2(1) A local board of health representing a geographic area with a population of at least 15,000 is eligible to apply for status as an approved program pursuant to Iowa Code section 135.104, which sets forth the eligibility requirements contained in the application.

72.2(2) A local board wishing to apply for status as an approved program shall make application to the department in the format available from the department. All materials submitted as part of the application for status as an approved program are public records.

These rules are intended to implement Iowa Code sections 135.100 through 135.105.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 74
“Family Planning Services”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.41B

State or federal law(s) implemented by the rulemaking: Iowa Code section 217.41B

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The intended benefit of this proposed rulemaking is to ensure that there is a successful process identified on how to fund eligible applicants for the Iowa Health and Human Services Title X Family Planning Program and what the grant application process consists of.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
Not applicable.
 - Qualitative description of impact:
Rulemaking authority is limited in scope. The chapter is being repealed. The portions of the chapter where rulemaking is mandated by Iowa Code will be moved into 641—Chapter 75. The remaining portions will continue to exist through the request for proposal process.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
None.

- Anticipated effect on state revenues:
No impact on state revenues is expected.

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

The chapter is being rescinded as part of the Executive Order 10 Red Tape Review process.

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

The chapter is being rescinded as part of the Executive Order 10 Red Tape Review process.

6. Alternative methods considered by the agency:

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

The chapter is being rescinded as part of the Executive Order 10 Red Tape Review process.

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

The chapter is being rescinded as part of the Executive Order 10 Red Tape Review process.

Small Business Impact

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

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

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

This rulemaking is not expected to have any effect on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 74**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 75

“Distribution of Federal Funds Restrictions—Provider Identification and Attestation”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 2019 Iowa Acts, House File 766, section 98, and 2023 Iowa Acts, Senate File 514, section 346

State or federal law(s) implemented by the rulemaking: 2019 Iowa Acts, House File 766, section 98; 2023 Iowa Acts, Senate File 514, section 346; and Title X of the Public Health Service Act, 42 U.S.C. §300 et seq.

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this rulemaking is to require that as a condition of eligibility as an applicant, grantee, grantee contractor, or grantee subcontractor for certain federal funds, each distinct location of a nonprofit health care delivery system will be assigned a distinct identification number and complete an attestation that abortions are not performed at the distinct location.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no associated costs.
 - Classes of persons that will benefit from the proposed rulemaking:
None, but no classes of persons will be harmed.
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:
None.
 - Qualitative description of impact:
None.
3. Costs to the State:

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

None.

- Anticipated effect on state revenues:

None.

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

Not applicable.

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

None.

6. Alternative methods considered by the agency:

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

The rulemaking is essentially a restatement of federal law, other agency rules, and federal and state program handbooks.

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

The statutory authority for the chapter states that the Department “shall” promulgate administrative rules.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 75 and adopt the following **new** chapter in lieu thereof:

CHAPTER 75

DISTRIBUTION OF FEDERAL FUND RESTRICTIONS—PROVIDER IDENTIFICATION AND ATTESTATION

641—75.1(88GA,ch85,90GA,ch19) Definitions.

“*Administer*” means to implement programs through contracts entered into by the department and selected private, governmental, and nonprofit organizations to provide programming directly to participants. “Administer” does not mean the evaluation of programs or the management of federal performance measures data collection. “Administer” also does not mean providing training and technical assistance.

“CAPP” means the community adolescent pregnancy prevention program using federal temporary assistance for needy families block grant funds appropriated to the department.

“Family planning” means the promotion of reproductive and family health through education, prevention of pregnancy, planning for pregnancy, and reproductive health services.

“FPP” means the state-funded family planning program that is a limited insurance coverage for men and women who are 12 to 54 years of age.

“Nonprofit health care delivery system” means an Iowa nonprofit corporation that controls, directly or indirectly, a regional health care network consisting of hospital facilities and various ambulatory and clinic locations that provide a range of primary, secondary, and tertiary inpatient, outpatient, and physician services.

“PREP” means the personal responsibility education program as specified in 42 U.S.C. Section 713 (as amended to January 1, 2024).

“SRAE” means the Sexual Risk Avoidance Education Grant Program authorized pursuant to Section 510 of Title V of the federal Social Security Act, 42 U.S.C. Section 710) as amended by the Consolidated Appropriations Act of 2022 (Public Law 117-103) and extended by division B, Title I, section 142, of the Further Additional Continuing Appropriations and Other Extensions Act, 2024 (Public Law 118-35), and the Further Consolidated Appropriations Act, 2024.

“Title X” refers to the federal requirements contained in 42 CFR Subpart A, Part 59 (as amended to August 1, 2024), and the Program Guidelines for Project Grants for Family Planning Services.

641—75.2(88GA,ch85,90GA,ch19) Distinct provider identification number and attestation.

75.2(1) The department will assign a unique identification number to each distinct location of a nonprofit health care delivery system receiving funds from the department to administer programs under:

- a. The Title X family planning program;
- b. PREP;
- c. SRAE;
- d. FPP; and
- e. CAPP grants.

75.2(2) Each applicant, grantee, grantee contractor, or grantee subcontractor, and each distinct location of a nonprofit health care delivery system receiving funds from the department as enumerated in subrule 75.2(1) shall provide to the department, on forms prescribed by the department, a signed attestation that abortions are not performed at the distinct location.

These rules are intended to implement 2019 Iowa Acts, chapter 85, sections 98 through 100, and 2023 Iowa Acts, chapter 19, section 346.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 76
“Maternal and Child Health Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 217.6

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.11

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter outlines the eligibility criteria and application procedures for Maternal and Child Health programs.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
Clients seeking assistance from Maternal and Child Health programs will benefit.
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:
These rules facilitate Iowa’s Title V program. For FFY 22, Iowa’s Title V program served:
 - 3,707 pregnant women
 - 1,111 infants < 1 year of age
 - 74,304 children aged 1 through 21 years of age
 - 8,006 children and youth with special health care needs (Child Health Specialty Clinics)
 - Qualitative description of impact:
These rules will benefit clients seeking assistance by providing structure, clarity and information.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

There are no additional costs beyond those already appropriated.

- Anticipated effect on state revenues:

There is no impact.

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

Eliminating these rules entirely could lead to confusion, lack of clarity and lack of available information for clients.

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

None were identified.

6. Alternative methods considered by the agency:

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

None.

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

Much of the benefit can be achieved through contracts and forms prescribed by the department.

However, an additional framework is needed to provide clarity, consistency and an appeals process.

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?

None were identified.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 76 and adopt the following **new** chapter in lieu thereof:

CHAPTER 76 MATERNAL AND CHILD HEALTH PROGRAM

641—76.1(135) Definitions.

“Care/service coordination” or “care coordination” means a comprehensive, family-centered approach that proactively engages and links clients and families to needed health care services, including medical, dental, emotional, behavioral, and health education services. Care coordination encompasses a specific set of activities that promote a client’s potential for optimal health and facilitate quality outcomes. By working with the client, family, and other involved disciplines, a care coordinator can promote seamless access and a holistic approach to service provision. Care coordination incorporates the following:

1. Meaningful assessment of needs and concerns.

2. Shared development of care plans.
3. Mobilization of agency and community resources.
4. Continued monitoring and follow-up.
5. Clear and transparent communication.
6. Complete documentation.

“Children and youth with special health care needs” or *“CYSHCN”* means children and youth with chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by children and youth generally.

“CHSC” means child health specialty clinics, a statewide program for children and youth with special health care needs authorized under Title V of the Social Security Act.

“Client” means an individual who receives MCH services through a contract agency.

“Contract agency” means a private nonprofit or public agency that has a contract with the department to provide MCH services and receives funds from the department for that purpose.

“DHHS” means the United States Department of Health and Human Services.

“Family,” for the purpose of establishing eligibility, means a group of two or more persons related by birth, marriage or adoption or residing together and functioning as one socioeconomic unit. For the purpose of these rules, a pregnant woman is considered as two individuals when calculating the number of individuals in the family. If a pregnant woman is expecting multiple births, the family size is thereby increased by the number expected in the multiple birth.

“Family planning” means the promotion of reproductive and family health by the prevention of and planning for pregnancy, and reproductive health education.

“Gap filling” means direct health care services supported by Title V staff or resources that are not otherwise accessible in the community.

“Hawki” means healthy and well kids in Iowa and is the child health insurance program in Iowa as authorized in Title XXI of the Social Security Act.

“Health care services” means services provided through MCH contract agencies.

“Health professional” means an individual who possesses specialized knowledge in a health or social science field or is licensed to provide health care.

“Medicaid” means the Medicaid program authorized by Title XIX of the Social Security Act and funded through the Iowa department of health and human services from the DHHS.

“Presumptive eligibility determination” means temporary Medicaid eligibility that pays for medical services while a formal Medicaid decision is being made by the Iowa department of health and human services. Presumptive eligibility is available for children, youth, and pregnant women.

“Title V” means Title V of the Social Security Act and the federal requirements contained in the Omnibus Reconciliation Act of 1989 (Public Law 101-239) that address the MCH and CYSHCN programs.

“Title X” means the program authorized in the federal regulations found in 42 CFR Subpart A, Part 59, published in the Federal Register on June 3, 1980, and the Program Guidelines for Project Grants for Family Planning Services.

“Title XIX” means the Medicaid program authorized in the Social Security Act and funded through the Iowa department of health and human services from the DHHS.

“Title XXI” means the child health insurance program authorized in the Social Security Act and implemented in Iowa as the Hawki program as administered by the Iowa department of health and human services.

“WIC” means the Special Supplemental Nutrition Program for Women, Infants and Children, funded through the department from the United States Department of Agriculture.

641—76.2(135) Client eligibility criteria. The certification process to determine eligibility for direct health care under the program shall include the following requirements:

76.2(1) Age.

- a. Maternal health program—no age restrictions.

- b. Child health program—birth through 21 years of age.
- c. CYSHCN program—birth through 21 years of age.

76.2(2) *Income.*

a. Income guidelines will be the same as those established for the state's Title XXI program. Guidelines are published annually by DHHS. Department income guidelines will be adjusted following any change in DHHS guidelines.

b. Income information will be provided by the individual.

c. Proof of Title XIX, Title XXI (hawki), or WIC eligibility will automatically serve in lieu of an application.

d. All income of family members as defined by DHHS poverty guidelines will be used in calculating the individual's gross income for purposes of determining initial and continued eligibility.

e. Income will be calculated as follows:

(1) Annual income will be estimated based on the individual's income for the past three months unless the individual's income will be changing or has changed, or

(2) In the case of self-employed families the past year's income tax return (adjusted gross income) will be used in estimating annual income unless a change has occurred,

(3) Terminated income will not be considered.

f. Individuals will be screened for eligibility for Title XIX, Title XXI (hawki), and WIC. If an individual's income falls within the eligibility guidelines for Title XIX, Title XXI (hawki), or WIC, the individual may be referred to the Iowa department of health and human services or other enrollment source to apply for coverage. Children, youth and pregnant women will be considered for Title XIX presumptive eligibility.

g. An individual whose income is above the poverty level established by Title XXI and below 302 percent of the federal poverty guidelines will qualify for services on a sliding fee scale, as determined by the local agency's cost for the service. The department provides annual guidelines based on poverty levels established annually by DHHS. An individual whose income is at or above 302 percent will qualify for services at full fee.

h. Eligibility determinations must be performed at least once annually. Should the individual's circumstances change in a manner that affects third-party coverage or Title XIX/Title XXI eligibility, eligibility determinations will be completed more frequently.

76.2(3) *Residency.* Individuals must be currently residing in Iowa.

76.2(4) *Pregnancy.* An individual applying for the prenatal program shall have verification of pregnancy by an independent health provider, the maternal health contract agency, a family planning (Title X) agency, or a positive home pregnancy test.

76.2(5) *Children and youth with special health care needs.* An individual applying for CHSC services will be determined to have a special health care need as defined by the federal MCHB. Care/service coordination, family support or other non-clinic services are provided at no charge to the family. Clinic services are provided without charge to families with adjusted gross incomes below 185 percent of the federal poverty guidelines. Families above this threshold are responsible for payment according to a sliding fee scale based on tax exemptions, adjusted gross income, and extenuating circumstances.

641—76.3(135) Client application procedures for MCH services. A person or the parent or guardian of a minor desiring direct health services other than those provided to children and youth with special health care needs may apply to a contract agency using a manner prescribed by the department. Individuals requesting presumptive eligibility must complete a form prescribed by the department, or the alternate form authorized by the medical assistance advisory council.

These rules are intended to implement Iowa Code section 135.11.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 78

“Personal Responsibility Education Program and Title V State Sexual Risk Avoidance Education Grant Program Funding and Restrictions”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 2019 Iowa Acts, House File 766, section 99

State or federal law(s) implemented by the rulemaking: 2019 Iowa Acts, House File 766, section 99

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this chapter is to set forth guidelines and limitations for the use of funds from the Personal Responsibility Education Program (PREP) and the Title V State Sexual Risk Avoidance Education (SRAE) Grant Program. The chapter details rules that prohibit the Department from contracting for PREP and SRAE programs with an entity that facilitates abortions. This chapter is proposed to be rescinded.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Not applicable.
 - Classes of persons that will benefit from the proposed rulemaking:
Not applicable.
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:
Not applicable.
 - Qualitative description of impact:

Rulemaking authority is limited in scope. The chapter is being rescinded. The portions of the chapter where rulemaking is mandated by the Iowa Code will be moved into 641—Chapter 75.

3. Costs to the State:

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

Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 78**.

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 81
“Nursing Facilities”

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

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A and 42 CFR 483

Public Hearing

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

November 7, 2024
10 a.m.

Microsoft Teams
Meeting ID: 295 147 282 130
Passcode: jm6rgf

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This chapter provides operational and Medicaid reimbursement rules for nursing facilities.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Owners and operators of nursing facilities in Iowa will bear the costs.
 - Classes of persons that will benefit from the proposed rulemaking:
Residents of Iowa nursing facilities who are enrolled in Medicaid will benefit.
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:
The quantitative impact will be a reduction of redundant language in the chapter.
 - Qualitative description of impact:
The qualitative impact will be to provide operational and reimbursement rules for nursing facilities. These rules and the underlying federal regulations allow the Department to hold providers accountable and help ensure quality care for nursing facility residents on Medicaid.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
This rulemaking will result in personnel and other administrative costs.
 - Anticipated effect on state revenues:
None.

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

The chapter is needed to provide information on reimbursement and quality standards for nursing facilities in Iowa. Without regulation, quality of care and the health and well-being of nursing facility residents could suffer.

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

Rulemaking is both required and necessary.

6. Alternative methods considered by the agency:

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

None.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 81 and adopt the following **new** chapter in lieu thereof:

CHAPTER 81 NURSING FACILITIES

441—81.1(249A) Definitions.

“Abuse” means any of the following that occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury that is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.
2. The commission of a sexual offense under Iowa Code chapter 709 or section 726.2 or 728.12(1), or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.
3. Exploitation of a resident, which means the act or process of taking unfair advantage of a resident or the resident's physical or financial resources for one's own personal or pecuniary profit

without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health.

"Advance directive" means the same as defined in 42 CFR 489.100 (as amended to August 1, 2024).

"Allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in rules.

"Beginning eligibility date" means date of an individual's admission to the facility or date of eligibility for medical assistance, whichever is the later date.

"Case mix" means a measure of the intensity of care and services used by similar residents in a facility.

"Case-mix index" means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

"Civil penalty" means a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

"Clinical experience" means application or learned skills for direct resident care in a nursing facility.

"Clock hour" means 60 minutes.

"CMS" means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

"Complete replacement" means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

"Cost normalization" refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility's per diem direct care component costs by the facility cost report period case-mix index.

"Denial of critical care" is a pattern of care in which the resident's basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident's serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

"Direct care component" means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. "Direct care component" also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

"Discharged resident" means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility.

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 (as amended to August 1, 2024) to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

"Facility-based nurse aide training program" means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

"Facility cost report period case-mix index" is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a

01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Level I review” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 (as amended to August 1, 2024).

“Level II review” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$750,000. The \$750,000 threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$750,000 threshold.

“Managed care organization” 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.

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or *“MDS”* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.5(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.5(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.5(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.5(16) “f.” MDS is described in subrule 81.12(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care that, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact that is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Non-state government owned nursing facility” or *“NSGO nursing facility”* is a nursing facility owned by a governmental entity that is not the state.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means the nurse aide registry within the department of inspections, appeals, and licensing.

“Nurse aide training and competency evaluation programs” or *“NATCEP”* means educational programs approved by the department of inspections, appeals, and licensing for nurse aide training as designated in subrule 81.13(3).

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C (as amended to August 1, 2024).

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury that is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue that results in the death of the person who has sustained the damage.

“Poor performing facility” or *“PPF”* is a facility designated by the department of inspections, appeals, and licensing as a PPF based on surveys conducted by the department of inspections, appeals, and licensing pursuant to subrule 81.12(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;

2. Has a history of substantiated complaints during the last two years;

3. Has a current deficiency for not having a quality assurance program; or

4. Does not have an effective quality assurance program as defined in paragraph 81.12(19) “o.”

“Primary instructor” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“Program coordinator” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“Rate determination letter” means the letter that is distributed quarterly by the department to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 (as amended to August 1, 2024).

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Skills performance record” means a record of major duties and skills taught that consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“Special population nursing facility” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with medical complexity.

“Surgical or other invasive procedure” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. *“Surgical or other invasive procedure”* does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“Terminated from the Medicare or Medicaid program” means a facility has lost the final appeal to which it is entitled.

“Testing entity” means a person, agency, institution, or facility approved by the department of inspections, appeals, and licensing to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4.

441—81.2(249A) Initial approval for nursing facility care.

81.2(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.2(1) “b,” will be made by the department within two working days of receipt of medical information. The department determines whether the

level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.2(3), the level of care determination will be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

81.2(2) *Preadmission review.* The department's contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person's care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department's contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person's attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person's physical condition, and the person is not a danger to self or others. If the person's nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person's illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person's caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.12(14)“b,” using the procedures set forth in 42 CFR 483.134 (as amended to August 1, 2024); and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.12(14)“c,” using the procedures set forth in 42 CFR 483.136 (as amended to August 1, 2024).

c. The department or its designee will review each Level II evaluation and plan for obtaining needed specialized services before the person’s admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.2(3)“a” has been approved, and it is determined by the department that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person’s treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident’s lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident’s consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident’s knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility’s bringing the state fair hearing on the resident’s behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“a” and 249A.4.

441—81.3(249A) Arrangements with residents.

81.3(1) *Financial participation by resident.* A resident’s payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.3(2) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident’s personal needs funds. (See paragraph 81.12(5)“c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.5(249A) if the service cannot be obtained free of charge. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident’s personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident’s total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the

accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department will turn the funds over to the estate.

81.3(3) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

441—81.4(249A) Discharge and transfer. (See paragraph 81.12(6) "c.")

81.4(1) *Notice.* When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.4(2) *Case activity report.* A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.4(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.4(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a.* A transfer form of diagnosis.
- b.* Aid to daily living information.
- c.* Transfer orders.
- d.* Nursing care plan.
- e.* Physician's orders for care.
- f.* The resident's personal records.

- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.4(5) *Unused client participation.* When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

441—81.5(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report to the department. All Medicare-certified hospital-based nursing facilities must submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.5(1) *Failure to maintain records.* Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility, may result in the penalties specified in subrule 81.14(1).

81.5(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

81.5(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the department not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.5(3) "e."

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.5(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate 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 the department.

(2) The reduced rate 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 the department.

f. When a nursing facility continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the department 60 days prior to the first date of the change.

81.5(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates will be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below will be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, will be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.5(16). In no case will the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.5(18), and 66.67 percent of

the July 1, 2002, modified price-based rate. In no case will the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.5(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities will be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities will be updated annually without a quarterly adjustment.

81.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.5(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.5(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.5(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.5(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinence, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.5(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following:

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal costs shall be prorated. Amounts that appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility that supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings that provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) 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 includes 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 shall 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 the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report will be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.5(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) 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.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.5(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.5(11) "h" (4) through 81.5(11) "h" (7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that 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 nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (2023 edition).

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.5(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) 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.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that 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; that the services, facilities, or supplies are those that 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 that the charge to the facility is in line with the charge for the 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, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.5(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11) "j" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.5(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11) "j" plus the landlord's other expenses; or

2. Actual rent payments.

n. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

o. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.5(21) "a."

p. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) "d." The department will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

q. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for

nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the department will adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments will be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

- r. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.
- s. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.
- t. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.
- u. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.5(12) Termination or change of owner:

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.5(13) *Amended reports.* The department, in its sole discretion, may 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 submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.5(14) *Payment to new facility.* The payment to a new facility will be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.5(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component will be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.5(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.5(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

81.5(15) *Payment to new owner.* An existing facility with a new owner will continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year. The facility shall notify the department of the date the facility’s fiscal year will end.

81.5(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate.

a. Calculation of per diem cost. For purposes of calculating the non-state government owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs will be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost will be determined by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001; July 1, 2003; July 1, 2004; July 1, 2005; and every second year thereafter, total reported allowable costs will be adjusted using the inflation factor specified in subrule 81.5(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state government owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state

government owned nursing facilities will be inpatient days as determined in subrule 81.5(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses will be inpatient days as determined in subrule 81.5(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.5(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.5(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median will be established for both the non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state government owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.5(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting will be recalculated. The non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.5(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, will be inflated to July 1, 2004, using the inflation factor specified in subrule 81.5(18).

d. Excess payment allowance.

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area as defined by CMS, not including Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day

direct care costs pursuant to 81.5(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider’s allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)“a.” In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area as defined by CMS (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider’s allowable normalized per patient day direct care costs pursuant to paragraph 81.5(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

The wage index factor will be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by CMS each July. The geographic wage index adjustment will not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department’s procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider’s allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)“a.” In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider’s normalized allowable per patient day direct care costs pursuant to paragraph 81.5(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater

than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16) "a." In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph "d," not to exceed the rate component limits determined by the methodology in paragraph "f."

(1) For non-state government owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.5(19), plus the allowed excess payment allowance as determined by the methodology in paragraph "d."

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph "d" and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph "h."

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities will be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.5(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs "d" and "e," in no instance will a rate component exceed the rate component limit defined as follows:

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph "h."

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph "d" times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph "h."

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median

specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Additional reimbursement based on the nursing facility pay-for-performance program is available for non-state government owned nursing facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types will not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The department will annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	Payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and	Payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
7 days per week and empowers staff to honor resident choices.			
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	Payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	Payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	Payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	Payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	Payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	Payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	Payment period	13 points NOTE: A facility that receives points for this measure does not receive	Self-certification

Standard	Measurement Period	Value	Source
		points for any other measures in this subcategory.	
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIAL list of facilities meeting the standard

Standard	Measurement Period	Value	Source
amended to August 1, 2024, the facility is deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.			
Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points. A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIAL list of facilities meeting the standard
Subcategory: Staffing			
Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities. Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours will be normalized to remove variations in staff hours associated with different levels of resident case mix.	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	Financial and Statistical Report, as analyzed by the department. The facility cost report period case-mix index shall be used to normalize nursing hours.
Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55% 10 points if overall turnover is less than or equal to 40% and CNA turnover is less	Financial and Statistical Report, as analyzed by the department

Standard	Measurement Period	Value	Source
		than or equal to 45%	
Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.	Calendar year ending December 31 of the payment period	5 points	Self-certification
Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility. To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the	Department report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
		mean percentage of occurrences	
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	Department report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	Department report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	Department report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIAL list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the	Financial and Statistical Report, as analyzed by the department

Standard	Measurement Period	Value	Source
determined by dividing total nursing facility Medicaid days by total nursing facility patient days.		median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. “Occupancy rate” is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Financial and Statistical Report, as analyzed by the department
Low Administrative Costs: The facility’s percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Financial and Statistical Report, as analyzed by the department

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data will be drawn from a report submitted by the facility to the department. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to the department on the Nursing Facility Opinion Survey Transmittal. The department will request required source reports from the long-term care ombudsman and the department of inspections, appeals, and licensing.

(10) Calculation of potential add-on payment. The number of points awarded will be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective

beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department will request the department of inspections, appeals, and licensing to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections, appeals, and licensing, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program will be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the department will:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.5(16) "g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete the Nursing Facility Medicaid Enhanced Payment Report to report the use of any additional payments received for the nursing facility pay-for-performance program. The report is due to the department each year by May 1. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department will publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the CMS and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “*f.*”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “*f.*” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services; or
3. Improving infection control by replacing or enhancing an HVAC system, as defined in Iowa Code section 105.2.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent. Medicaid patient day utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total patient days as reported on the facility’s most current financial and statistical report. Medicaid hospice patient days will be counted toward the total nursing facility Medicaid patient days.

2. The facility meets the accountability measure criteria set forth in paragraph “*g.*” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.

4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the department. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule that clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days will be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

- (8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.

2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.

3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).

4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

- (9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days will be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days will be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government-owned facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. Estimated amounts and actual amounts will be reconciled as described in subparagraph (12).

- (10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on will be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

- (11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

- (12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the department will recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual

financial and statistical report. A separate reconciliation will be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days will be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period will be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid will be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit will be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date will be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval will be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the department is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership will continue under the new owner. Future reimbursement rates will be determined pursuant to subrules 81.5(15) and 81.5(16).

i. Quality incentive payment program (QIPP). The QIPP add-on rate will be made to a qualified non-state government-owned nursing facility (NSGO nursing facility) to promote, maintain, and improve resident quality of care and health outcomes.

(1) An NSGO nursing facility qualifies for participation in the QIPP if all the following conditions are met:

1. The NSGO nursing facility has executed a participation agreement with the department.
 2. The NSGO nursing facility has provided proof that the entity holds the NSGO nursing facility's license and has complete operational responsibility for the NSGO nursing facility.
 3. The NSGO nursing facility has filed a certification of eligibility application for the QIPP add-on rate program with the department and has received approval from the department for participation in the program.
 4. The NSGO nursing facility is in compliance with all care criteria requirements.
 5. The non-state government entity (NSGE) has executed a nursing facility provider contract with an NSGO nursing facility.
 6. The NSGE has provided and identified the source of state share dollars for the intergovernmental transfer (IGT).
 7. The NSGO nursing facility has provided proof of ownership, if applicable, as the licensed operator of the NSGO nursing facility.
 8. The NSGO nursing facility has provided to the department an executed management agreement between the NSGE and the NSGO nursing facility manager if applicable.
- (2) If at any time a provider is determined not eligible due to not meeting survey standards, the provider will be disqualified for the remainder of the year.
- (3) An NSGO nursing facility will qualify for participation in the QIPP if all the following quality measures are met:

Quality Measures	Metrics	Tracking/Scoring	Data Resource
Staffing	Metric 1: Nursing facility maintains an additional four or more hours of registered nurse (RN) coverage per day beyond the CMS minimum standard (8 hrs/day). Does not include managerial hours. Metric 2: Nursing facility's per-resident day certified nursing assistants (CNAs), rehabilitation aid, and other contracted aid services are at or above one-half standard deviation above the statewide mean of per-resident-day CNA hours. CNA hours include those of CNAs, rehabilitation aid, and other contracted aide services. CNA hours will be normalized to remove variations in staff hours associated with different levels of resident case mix. Metric 3: Nursing facility's per-resident day total nursing hours are at or above one-half standard deviation above the statewide mean of per-resident-day total nursing hours. Nursing hours include those of RNs and licensed practical nurses (LPNs) including restorative nurses. Nursing hours will be normalized to	Staffing metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Payroll-based journal (PBJ) or cost reports

	remove variations in staff hours associated with different levels of resident case mix.		
Infection Control	Metric 1: Nursing facility has an infection control program that includes antibiotic stewardship. The program incorporates policies and training as well as monitoring, documenting, and providing staff with feedback. Metric 2: Percentage of residents with urinary tract infections (UTIs) at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on minimum data set (MDS) data as applied to the nationally reported quality measures. Metric 3: Percentage of residents with up-to-date pneumonia vaccine measured against a fixed benchmark that is set as the most recently published national average for the related MDS quality metric.	Infection control metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Nursing facility will be required to provide its infection control policy and procedure. In addition, facilities will need to provide information regarding training, monitoring, documentation and monitoring of required elements to meet this metric on a periodic basis CASPER Report MDS Assessment Care Compare
Quality Measures	Metric 1: Percentage of high-risk residents with pressure ulcers (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. Metric 2: Percentage of residents who had a fall with major injury (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. Metric 3: Percentage of residents who received antipsychotic medications are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. Metric 4: Percentage of residents who required increased activities of daily living (ADL) assistance (for	Quality measures metrics 1, 2, 3, and 4 must be met for the facility to be eligible for per diem rate add-on payment.	CASPER Report MDS Assessment Care Compare

longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.

State Survey Results	Number of deficiencies is at or below the state of Iowa average number of nursing facility deficiencies <u>AND</u> the facility has no deficiencies with a scope of F, H, I, J, K, or L.	State survey results must be met for the facility to be eligible for per diem rate add-on payment.	Department of inspections, appeals, and licensing (DIAL) surveys
Quality Assurance Performance Improvement (QAPI) Report	Nursing facility must submit QAPI reports on quarterly basis.	QAPI results must be submitted for the facility to be eligible for per diem rate add-on payment.	QAPI reports

(4) A provider must submit the Intent to Participate Agreement on or before September 30 each year and include all necessary documentation related to the quality measures.

1. Upon receipt of the participation agreement, the department will complete a determination of eligibility based on the care criteria defined above.
2. Providers will be notified of their eligibility annually within 60 days of the agreement due date.

(5) The nursing facility QIPP add-on rate provided to a participating NSGO nursing facility under the QIPP will not exceed Medicare payment principles pursuant to 42 CFR 447.272 (as amended to August 1, 2024) and will be calculated pursuant to 42 CFR 438.6 (as amended to August 1, 2024). The QIPP add-on rate will be calculated and paid as follows:

1. The methodology utilized to calculate the upper payment limit will be based on the data available during the calculation period.
2. The eligible amount used in determining the QIPP add-on rate will be the difference between the state Medicaid payment and the Medicare upper payment limit as determined, on an annual basis, using all Medicaid claims, including fee-for-service (FFS) and Medicaid managed care claims.
3. The difference calculated under numbered paragraph “2” will be divided by total patient days pursuant to subrule 81.5(7).
4. The QIPP add-on rate will be paid prospectively.

(6) A participating NSGO nursing facility shall notify the department of any change of ownership that may affect the participating NSGO nursing facility’s continued eligibility for the QIPP a minimum of 30 days prior to such change.

1. If a participating NSGO nursing facility changes ownership to a privately owned entity, on or after the first day of the QIPP add-on rate calculation period, the privately owned provider is no longer eligible for the QIPP add-on rate.
2. A participating facility must meet the CMS and department requirements to be classified as an NSGO nursing facility. All changes of ownership must be a fair market value transaction.
3. If it is determined that a provider is not a qualified NSGO nursing facility per CMS and the department, the provider shall repay all QIPP add-on payments to the department.

(7) Providers that do not meet eligibility requirements above will be notified of the metrics that were not met.

(8) A participating NSGO nursing facility shall secure allowable intergovernmental transfer funds from a participating NSGE to provide the state share amount. The process for the intergovernmental transfer shall comply with the following:

1. The department, or the department's designee, will notify the participating NSGO nursing facility of the state share amount to be transferred in the form of an intergovernmental transfer for purposes of seeking federal financial participation for the QIPP add-on rate, within 15 business days after the end of each month. The participating NSGO shall have until the end of the month to remit payment of the state share amount in the form of an intergovernmental transfer to the department or the department's designee.

2. If there is any outstanding intergovernmental transfer amount at the end of the payment period, the provider will not be able to participate in the QIPP the following year.

81.5(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.5(18) Inflation factor. The department will consider an inflation factor in determining the reimbursement rate. The inflation factor will be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting will be used to determine the inflation factor.

81.5(19) Case-mix index calculation.

a. The RUG-III Version 5.12b, 34 group, index maximizer model will be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.12(9). Standard Version 5.12b case-mix indices developed by CMS will be the basis for calculating the average case-mix index and will be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.5(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment will be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group will be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility will be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors will be excluded from both average case-mix index calculations.

81.5(20) Medicare crossover claims for nursing facility services.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. 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.

“Medicaid-allowed amount” means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

“Medicaid reimbursement” includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

“Medicare payment amount” means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.5(21) Nursing facility quality assurance payments.

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance assessment pass-through will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through will equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance add-on of \$15 per patient day will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on the Nursing Facility Medicaid Enhanced Payment Report demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference will be used to increase compensation and costs of employment for direct care workers determined pursuant to Iowa Code section 249L.4.

(2) No less than 60 percent of the difference will be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to Iowa Code section 249L.4.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 has been approved by CMS, none of the nursing facility rate-setting methodologies of this subrule will become effective.

e. End date. If CMS determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule will be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department will:

- (1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;
- (2) Recompute Medicaid payments due based on the recalculated Medicaid rates;
- (3) Recoup any previous overpayments; and
- (4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

441—81.6(249A) Continued review.

81.6(1) *Level of care.* The department will review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.2(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the member's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

81.6(2) *PASRR.* As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

- a.* Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);
- b.* Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and
- c.* Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.2(3) "*b.*"

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.

441—81.7(249A) Records.

81.7(1) *Content.* The facility shall as a minimum maintain the following records:

- a.* All records required by the department and the department of inspections, appeals, and licensing.
- b.* Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.
- c.* Documentation in each resident's records that will enable the department to verify that each charge is due and proper prior to payment.
- d.* Financial records maintained in the standard, specified form including the facility's most recent audited cost report.
- e.* All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.
- f.* Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.
 - (1) Census information shall be provided for all residents of the facility.
 - (2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

- g. Resident accounts.
- h. In-service education program records.
- i. Inspection reports pertaining to conformity with federal, state and local laws.
- j. Residents' personal records.
- k. Residents' medical records.
- l. Disaster preparedness reports.

81.7(2) *Retention.* Records identified in subrule 81.7(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.7(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.8(249A) Payment procedures.

81.8(1) *Method of payment.* Except for Medicaid accountability measures payment established in paragraph 81.5(16) "g," facilities will be reimbursed under a modified price-based vendor payment program. A per diem rate will be established based on information submitted according to rule 441—81.5(249A). The per diem rate will include an amount for Medicaid accountability measures.

81.8(2) *Authorization of payment.* The department will authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.8(3) *Periods authorized for payment.*

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit, vacation, or hospitalization will be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which will be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care will be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. Ventilator patients.

(1) **Definition.** For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) **Reimbursement.** In-state nursing facilities will receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in

subparagraph 81.5(16)“f”(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

i. Payment for residents of a special population facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that the department may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

- (1) The wrong surgical or other invasive procedure is performed on a resident; or
- (2) A surgical or other invasive procedure is performed on the wrong body part; or
- (3) A surgical or other invasive procedure is performed on the wrong resident.

81.8(4) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the department as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2)“d,” medical supplies except for those listed in 441—paragraph 78.10(4)“b,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The department will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

- (1) Physician services.

- (2) Ambulance services.
- (3) Hospital services.
- (4) Hearing aids, braces and prosthetic devices.
- (5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

- (1) Drugs covered pursuant to 441—subrule 78.1(2).
- (2) Dental services.
- (3) Optician and optometrist services.
- (4) Repair of medical equipment and appliances that belong to the resident.
- (5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.
- (6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR 483.10 (as amended to August 1, 2024).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident’s subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility’s occupancy rate was less than 50 percent as of the first day of the month or as of the resident’s subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall notify all residents, prospective residents, and their legal representatives in accordance with Iowa Code section 249A.4(10)“b”(1).

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident’s record the information set forth in Iowa Code section 249A.4(10)“b”(2).

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.8(3) "j" and shall not discharge a resident due to nonpayment for such days.

This rule is intended to implement Iowa Code section 249A.4.

441—81.9(249A) Billing procedures. Claims for service must be sent to the department after the month of service and within 365 days of the date of service. Claims must be submitted electronically through the department's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the department. A request for an adjustment to a paid claim must be received by the department within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.10(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.11(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

81.11(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with department of health and human services publication "State Operations Manual" (as amended to August 1, 2024).

81.11(2) Medicaid provider agreements.

a. The health care facility shall be recommended for certification by the department of inspections, appeals, and licensing for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with department of health and human services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

b. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

81.11(3) Distinct part requirement. All facilities that provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections, appeals, and licensing.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work there regularly. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.11(4) *Civil rights.* The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 (as amended to August 1, 2024) in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.11(5) *Resident rights.* The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident in accordance with 42 CFR 483.10 (as amended to August 1, 2024).

81.11(6) *Admission, transfer and discharge rights.*

a. Definition. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

b. Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident, in accordance with 42 CFR 483.15 (as amended to August 1, 2024).

81.11(7) *Resident behavior and facility practices.*

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections, appeals, and licensing) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections, appeals, and licensing) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.11(8) *Quality of life.* A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life in accordance with 42 CFR 483.10 (as amended to August 1, 2024).

a. Activities. The facility shall provide for an ongoing program of activities designed to meet, based on the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident in accordance with 42 CFR 483.24(c) (as amended to August 1, 2024).

b. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis in accordance with 42 CFR 483.70(p) (as amended to August 1, 2024).

c. Environment. The facility shall provide a safe, clean, comfortable and homelike environment in accordance with 42 CFR 483.10(i) (as amended to August 1, 2024).

81.11(9) *Resident assessment.* The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability in accordance with 42 CFR 483.20(a) through (j) (as amended to August 1, 2024).

a. Use of independent assessors. If the department or the department of inspections, appeals, and licensing determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements in a resident assessment, the department or the department of inspections, appeals, and licensing may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department or the department of inspections, appeals, and licensing for a period specified by the agency.

b. Comprehensive care plans. The facility shall develop a comprehensive care plan for each resident in accordance with 42 CFR 483.21(b) (as amended to August 1, 2024).

c. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary in accordance with 42 CFR 483.21(c)(2) (as amended to August 1, 2024).

d. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.11(10) *Quality of care.* Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A facility shall ensure that residents receive treatment in accordance with 42 CFR 483.24 and 483.25 (as amended to August 1, 2024).

a. Behavioral health services. Based on the comprehensive assessment of a resident, the facility shall ensure that residents receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with 42 CFR 483.40 (as amended to August 1, 2024).

b. Unnecessary drugs. Each resident's drug regimen shall be free from unnecessary drugs in accordance with 42 CFR 483.45(d) and (e) (as amended to August 1, 2024).

c. Medication errors. The facility shall ensure that it meets the standards set forth in 42 CFR 483.45(f) (amended to August 1, 2024).

81.11(11) *Nursing services.* In accordance with 42 CFR 483.35 (as amended to August 1, 2024), the facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

81.11(12) Dietary services. In accordance with 42 CFR 483.60 (as amended to August 1, 2024), the facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

81.11(13) Physician services. In accordance with 42 CFR 483.30 (as amended to August 1, 2024), a physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

81.11(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician in accordance with 42 CFR 483.65 (as amended to August 1, 2024).

b. Specialized services for mental illness. “Specialized services for mental illness” means services provided in response to an exacerbation of a resident’s mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;
- (4) May be provided only by a specialized licensed or certified practitioner;
- (5) Are expected to result in specific, identified improvements in the resident’s psychiatric status to the level before the exacerbation of the resident’s mental illness; and

(6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.
2. Initial psychiatric evaluation to determine a resident’s diagnosis and to develop a plan of care.
3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.
4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.
5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.
6. Any clinically appropriate service that is available for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. “Specialized services for intellectual disability” means services that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;
- (4) Must be supervised by a qualified intellectual disability professional; and
- (5) May include:
 1. A functional assessment of maladaptive behaviors.
 2. Development and implementation of a behavioral support plan.
 3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.11(15) Dental services. In accordance with 42 CFR 483.55 (as amended to August 1, 2024), the facility shall assist residents in obtaining routine and 24-hour emergency dental care.

81.11(16) Pharmacy services. In accordance with 42 CFR 483.45 (as amended to August 1, 2024), the facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

81.11(17) Infection control. In accordance with 42 CFR 483.80 (as amended to August 1, 2024), the facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

81.11(18) Physical environment. In accordance with 42 CFR 483.90 (as amended to August 1, 2024), the facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

81.11(19) Administration. In accordance with 42 CFR 483.70(a) through (d) (as amended to August 1, 2024), a facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Required training of nurse aides.

(1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis in accordance with the exceptions and provisions specified in 42 CFR 483.25(d) (as amended to August 1, 2024).

b. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

c. Staff qualifications. Staff qualifications must be met in accordance with 42 CFR 483.70(f) (as amended to August 1, 2024).

d. Use of outside resources. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in 42 CFR 483.70(g) (as amended to August 1, 2024).

e. Medical director. The facility shall designate a physician to serve as medical director in accordance with 42 CFR 483.70(h) (as amended to August 1, 2024).

f. Laboratory, radiology, and other diagnostic services. The facility shall provide or obtain clinical laboratory, radiology, and other diagnostic services to meet the needs of its residents in accordance with 42 CFR 483.50 (as amended to August 1, 2024).

g. Clinical records. The facility shall maintain clinical records on each resident in accordance with 42 CFR 483.70(i) (as amended to August 1, 2024).

h. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

i. Transfer agreement. The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs in accordance with 42 CFR 483.70(j) (as amended to August 1, 2024).

j. Quality assessment and assurance. A facility shall maintain a quality assessment and assurance committee in accordance with 42 CFR 483.75(g) through (i) (as amended to August 1, 2024).

k. Disclosure of ownership.

(1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104 (as amended to August 1, 2024).

(2) The facility shall provide written notice to the department of inspections, appeals, and licensure at the time of change, if a change occurs in:

1. Persons with an ownership or control interest.
2. The officers, directors, agents, or managing employees.

3. The corporation, association, or other company responsible for the management of the facility.

4. The facility's administrator or director of nursing.

(3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

441—81.12(249A) Audits.

81.12(1) *Audit of financial and statistical report.* Authorized representatives of the department or the U.S. Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report are reasonable and proper according to the rules set forth in rule 441—81.5(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.12(2) *Audit of proper billing and handling of patient funds.*

a. The department; the department's contracted managed care organizations; field auditors of the department of inspections, appeals, and licensing; and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department; the department's contracted managed care organizations; field auditors of the department of inspections, appeals, and licensing; and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.3(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation indicating that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “d,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a” and 249A.4.

441—81.13(249A) Nurse aide requirements and training and testing programs.

81.13(1) *Deemed meeting of requirements.* A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections, appeals, and licensing if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours’ duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections, appeals, and licensing determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.13(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections, appeals, and licensing will, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of paragraph 81.11(19) “e” and subrule 81.14(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections, appeals, and licensing approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections, appeals, and licensing will determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.14(3).

2. A nurse aide competency evaluation program meets the requirements of 81.14(4).

(2) Except as provided by paragraph 81.14(2)“f,” the department of inspections, appeals, and licensing will not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility that, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment.

c. Application process. Applications shall be submitted to the department of inspections, appeals, and licensing before a new program begins and every two years thereafter on a form prescribed by the department. The department of inspections, appeals, and licensing will, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections, appeals, and licensing will not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections, appeals, and licensing and the department of inspections, appeals, and licensing will review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval. The department of inspection, appeals, and licensing will follow the provision of 42 CFR 483.151(e) (as amended to August 1, 2024) regarding withdrawals of approvals.

f. An exception to subparagraph 81.14(2)“b”(2) may be granted by the department of inspections, appeals, and licensing for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted a Nurse Aide Education Program Waiver Request, to the department of inspections, appeals, and licensing to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved NATCEP.

(3) No other NATCEP is offered within 30 minutes’ travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by the department of inspections, appeals, and licensing.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the department of inspections, appeals, and licensing indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to

contact the department of inspections, appeals, and licensing to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP that shall return the evaluations to department of inspections, appeals, and licensing.

81.13(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections, appeals, and licensing to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in 42 CFR 483.152 (as amended to August 1, 2024).

a. If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

(1) Add all costs incurred by the nurse aide for the course, books, and competency evaluations.

(2) Divide the total arrived at in subparagraph (1) above by 12 to prorate the costs over a one-year period and establish a monthly rate.

(3) The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

b. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

c. Records and reports. Nurse aide education programs approved by the department of inspections, appeals, and licensing shall:

(1) Notify the department of inspections, appeals, and licensing:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.

2. When a facility or other training entity will no longer be offering nurse aide training courses.

3. Whenever the person coordinating the training program is hired or terminates employment.

(2) Keep a list of faculty members and their qualifications available for department review.

(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.

(4) Complete a lesson plan for each unit that includes behavioral objectives, a topic outline and student activities and experiences.

(5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.13(4) *Nurse aide competency evaluation.* Nurse aid competency evaluation program shall be administered in accordance with 42 CFR 483.154 (as amended to August 1, 2024).

a. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

b. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas that the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

c. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

d. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections, appeals, and licensing. The department of inspections, appeals, and licensing shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.13(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections, appeals, and licensing shall establish and maintain a registry of nurse aides in accordance with 42 CFR 483.156 (as amended to August 1, 2024). In addition, the registry shall contain a record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment, or misappropriation of resident property.

b. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry.

(1) Persons employed as nurse aides shall complete the Nurse Aide Registry Application within the first 30 days of employment. This form shall be submitted to the department of inspections, appeals, and licensing. The application may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed application to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.13(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections, appeals, and licensing will investigate that allegation. When the investigation makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections, appeals, and licensing. The hearing shall be held pursuant to 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.13(7) Appeals. Adverse decisions made by the department of inspections, appeals, and licensing in administering these rules may be appealed pursuant to 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.

441—81.14(249A) Sanctions.

81.14(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty in accordance with 42 CFR 483.20(j) (as amended to August 1, 2024).

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections, appeals, and licensing or the director's designee may consider evidence of the circumstances surrounding the violation, including but not limited to the following factors:

(1) The number of assessments willingly and knowingly falsified.

(2) The history of the individual relative to previous assessment falsifications.

(3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.

(4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections, appeals, and licensing in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections, appeals, and licensing may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.14(2) *Use of independent assessors.* If the department of inspections, appeals, and licensing determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections, appeals, and licensing may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

b. The department of inspections, appeals, and licensing will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections, appeals, and licensing before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections, appeals, and licensing for completing its own assessments.

(3) The department of inspections, appeals, and licensing will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections, appeals, and licensing within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision that may be appealed to the director of the department of inspections, appeals, and licensing pursuant to 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.14(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

This rule is intended to implement Iowa Code section 249A.4.

441—81.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.15(1) Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state government owned nursing facility direct care rate component limit pursuant to subparagraph 81.5(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.5(16)“f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.5(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.5(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.5(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.5(249A).

81.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.

441—81.16(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, chapter 267, section 132(1) “i.”

441—81.17(249A) Rates for Medicaid eligibles.

81.17(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.5(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.17(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.

441—81.18(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

441—81.19(249A) Enforcement of compliance. Enforcement of compliance with this chapter shall occur in accordance with 42 CFR 488 (as amended to August 1, 2024).

441—81.20(249A) Appeal of a determination of noncompliance.

81.20(1) A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections, appeals, and licensing within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

a. A request for a hearing shall be made in writing to the department of inspections, appeals, and licensing within 60 days from receipt of the notice.

b. Hearings shall be conducted pursuant to 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections, appeals, and licensing as the final decision maker, with subject matter jurisdiction.

81.20(2) A facility may not appeal the choice of remedy, including the factors considered by the department of inspection, appeals, and licensing in selecting the remedy.

81.20(3) A facility may not challenge the level of noncompliance found by the department of inspections, appeals, and licensing, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections, appeals, and licensing

only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

81.20(4) Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.21(249A) Civil money penalties—when penalty is collected. The collection of civil money penalties is made as provided in rule 441—81.24(249A).

441—81.22(249A) Civil money penalties—settlement authority. The department of inspections, appeals, and licensing has the authority to settle cases at any time before an evidentiary hearing.

441—81.23(249A) Civil money penalties—deduction of penalty from amount owed.

81.23(1) The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.23(2) Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

441—81.24(249A) Use of penalties collected by the department. Civil money penalties collected by the department will be applied to the protection of the health or property of residents of facilities that the department of inspections, appeals, and licensing finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

These rules are intended to implement Iowa Code section 249A.4.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 87
“Healthy Families Iowa (HFI)”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.106

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

Currently, this chapter describes applicant and participant eligibility, program requirements, contractor assurances, and the applicant and participant appeals process for Healthy Families Iowa. Authority is not explicit for rulemaking; however, the Department has established criteria, program requirements and a request for proposal process for the program. Chapter rescission is appropriate.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
Because the substance of this chapter will remain present in the established criteria, program requirements and request for proposal, no impacts were identified.
 - Qualitative description of impact:
Because the substance of this chapter will remain present in the established criteria, program requirements and request for proposal, no impacts were identified.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 87**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 89
“Parental Notification of Intent to Terminate a Pregnancy Through Abortion”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135L

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 135L

Public Hearing

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

November 6, 2024
2 to 3 p.m.

Microsoft Teams
Meeting ID: 238 807 808 374
Passcode: sCAuM5

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

These proposed rules provide the procedures and documentation necessary for notification of a parent or grandparent of a pregnant minor prior to the termination of the pregnancy through abortion.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Medical providers will bear the costs.
 - Classes of persons that will benefit from the proposed rulemaking:
Medical providers will benefit.

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:

No quantitative impact for this rulemaking has been identified. The decision-making assistance program is established in Iowa Code chapter 135L. There are no substantive changes to rules related to notification procedures, also established in Iowa Code chapter 135L.

- Qualitative description of impact:

The rules in this chapter provide clarity and structure to medical providers regarding the specific procedural requirements for notifying a parent or grandparent of a pregnant minor seeking the termination of a pregnancy through abortion.

3. Costs to the State:

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

The Department incurs personnel costs to support the execution of the procedures described in this chapter.

- Anticipated effect on state revenues:
No impact was identified.

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

The absence of these procedures could lead to lack of understanding or confusion for medical providers regarding the specific procedural requirements for notifying a parent or grandparent of a pregnant minor seeking the termination of a pregnancy through abortion.

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

A less costly method has not been identified to achieve the purpose of this rulemaking.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
None. This chapter implements notification procedures as mandated by the Iowa Code.
- Reasons why alternative methods were rejected in favor of the proposed rulemaking:
These procedures are mandated by the Iowa Code.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 89 and adopt the following **new** chapter in lieu thereof:

CHAPTER 89 PARENTAL NOTIFICATION OF INTENT TO TERMINATE A PREGNANCY THROUGH ABORTION

641—89.1(135L) Definitions.

“*Abortion*” means an abortion as defined in Iowa Code chapter 146C.

“*Court*” means juvenile court.

“*Grandparent*” means the same as defined in Iowa Code chapter 135L.

“*Licensed physician*” means a physician as licensed by the Iowa board of medical examiners.

“*Medical emergency*” means the same as defined in Iowa Code chapter 135L.

“*Minor*” means the same as defined in Iowa Code chapter 135L.

“Parent” means the same as defined in Iowa Code chapter 135L.

641—89.2(135L) Notification of parent prior to the performance of abortion on a pregnant minor.

89.2(1) Notification is made to the parent pursuant to Iowa Code section 135L.3, unless a judicial waiver is granted as provided in Iowa Code section 135L.3, or unless any of the conditions of rule 641—89.3(135L) have been met.

a. The notification form shall be in duplicate and may be provided by the department and include, at a minimum, the following:

- (1) The name of the minor.
- (2) Notification of the intent to terminate the pregnancy.
- (3) The name, address, and relationship of the person to be notified.

b. The licensed physician who performs the abortion will keep the original notification form as a part of the minor’s medical record relating to the termination of the pregnancy.

c. A copy of the completed notification form is provided to the pregnant minor.

89.2(2) Reserved.

641—89.3(135L) Notification procedures in the event of an exception.

89.3(1) The licensed physician who performs the abortion will keep all written documentation as a part of the minor’s medical record relating to the termination of the pregnancy.

89.3(2) Upon receipt of the written statement from the pregnant minor, the licensed physician who performs the abortion provides notification to a grandparent of the pregnant minor, specified by the pregnant minor, in the manner in which the notification of a parent was prescribed in rule 641—89.2(135L).

a. The notification form shall be in duplicate and may be provided by the department, and include, at a minimum, the following:

- (1) The name of the minor.
- (2) Notification of the intent to terminate the pregnancy.
- (3) The name, address, and relationship of the person to be notified.
- (4) A declaration that informs the grandparent of the pregnant minor that the grandparent of the pregnant minor may be subject to civil action if the grandparent accepts notification.
- (5) A provision that the grandparent of the pregnant minor may refuse acceptance of notification and a provision that the grandparent immediately contact the licensed physician if refusing acceptance of the notification.

b. A copy of the completed notification form is to be provided to the pregnant minor.

These rules are intended to implement Iowa Code chapter 135L as amended by 1997 Iowa Acts, House File 121.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 91
“Iowa Domestic Abuse Death Review Team”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.112

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.108

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of the Domestic Abuse Death Review Team is to aid in the reduction of the incidence of domestic abuse deaths by accurately identifying the cause and manner of deaths occurring from domestic violence and by making recommendations for changes in policy and practice to improve community interventions for preventing domestic abuse deaths.

The State Mortality Review Committee (2024 Iowa Acts, Senate File 2385) prompted the centralization of death review teams. Chapter 91 is being rescinded and centralized with 641—Chapters 5, 90 and 92. Procurement and review will continue to occur as part of this centralized chapter, and as a subcommittee of the State Mortality Review Committee.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Not applicable.
 - Classes of persons that will benefit from the proposed rulemaking:
Not applicable.
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:
Because procurement and review will continue to occur as part of a centralized chapter, and as a subcommittee of the State Mortality Review Committee, no impacts were identified.
 - Qualitative description of impact:

Because procurement and review will continue to occur as part of a centralized chapter, and as a subcommittee of the State Mortality Review Committee, no impacts were identified.

3. Costs to the State:

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

Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 91.**

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 92
“Iowa Fatality Review Committee”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.43

State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of the Child Fatality Review Committee is to determine whether the Department and others involved with the case of child abuse responded appropriately.

The State Mortality Review Committee (2024 Iowa Acts, Senate File 2385) prompted the centralization of death review teams. Chapter 92 is being rescinded and centralized with 641—Chapters 5, 90 and 91. Procurement and review will continue to occur as part of this centralized chapter and as a subcommittee of the State Mortality Review Committee.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Not applicable.
 - Classes of persons that will benefit from the proposed rulemaking:
Not applicable.
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:
Because procurement and review will continue to occur as part of a centralized chapter and as a subcommittee of the State Mortality Review Committee, no impacts were identified.
 - Qualitative description of impact:
Because procurement and review will continue to occur as part of a centralized chapter and as a subcommittee of the State Mortality Review Committee, no impacts were identified.

3. Costs to the State:

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

Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 92.**

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 94
“Child Protection Center Grant Program”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.118

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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 (Department) no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

Currently, this chapter describes the goals, review process, eligibility criteria and appeals process for the Child Protection Center Grant Program. However, this chapter is duplicative of the request for proposal process and appeals procedures set forth in 441—Chapter 7. Authority is not explicit in the Iowa Code to allow for rulemaking, and chapter rescission is appropriate.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
Because the substance of this chapter will remain present in 441—Chapter 7 and the established request for proposal, application and review process, no impacts were identified.
 - Qualitative description of impact:
Because the substance of this chapter will remain present in 441—Chapter 7 and the established request for proposal, application and review process, no impacts were identified.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

Not applicable.

- Anticipated effect on state revenues:

Not applicable.

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

Not applicable.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 94.**

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 113
“Public Health Response Teams”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.143

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.143

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The primary purpose of public health response teams is to respond to Iowa incidents and to provide support for Iowa medical and public health personnel, hospitals, and resources. A public health response team (PHRT) may also be requested to respond to an out-of-state disaster or emergency pursuant to the emergency management assistance compact in Iowa Code section 29C.21.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this proposed rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Local communities and citizens during times of disaster will benefit.
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:
Since 2004, the following PHRTs have been deployed as follows:
Logistical Support Response Team (LSRT)
Disaster Medical Assistance Team (DMAT)
Environmental Health Response Team (EHRT)
Iowa Mortuary Operations Response Team (IMORT)
 - October 4, 2022 EHRT—meeting for possible deployment to Florida
 - March 10, 2020—COVID-19 Repatriation Mission

- March 15, 2020 LSRT—Lucas Building Mission
- April 24, 2020 DMAT—Wells Fargo NP testing Des Moines Mission
- 2012 LSRT—Creston, Iowa, Tornado
- 2008 DMAT—Cedar Rapids, Iowa, Floods
- 2005 EHRT—Hurricane Katrina
- 2004 DMAT—Florida Hurricane

- Qualitative description of impact:

This chapter outlines the responsibilities of PHRTs, including activation, deployment, volunteer protections, trainings, and duties while deployed in disasters.

3. Costs to the State:

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

Personnel and other administrative costs.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues.

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

Rulemaking is both appropriate and required by law. Without PHRTs, there would be no infrastructure and support for Iowa communities and citizens during times of disaster.

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

No. Rulemaking is both appropriate and required by law.

6. Alternative methods considered by the agency:

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

None.

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

Rulemaking is both appropriate and required by law.

Small Business Impact

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

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

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

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 113 and adopt the following **new** chapter in lieu thereof:

CHAPTER 113
PUBLIC HEALTH RESPONSE TEAMS

641—113.1(135) Definitions. For purposes of this chapter, the following definitions apply:

“Defend” means that the office of the Iowa attorney general shall provide a public health response team member with legal representation at no cost to the public health response team member.

“Disaster medical assistance team” or *“DMAT”* means a public health response team that is sponsored and approved by the department, to provide medical assistance in the event of a disaster or threatened disaster or other incident as defined in Iowa Code section 135.143.

“Environmental health response team” or *“EHRT”* means a public health response team that is sponsored and approved by the department to provide environmental health expertise and assistance in the event of a disaster or threatened disaster or other incident defined in Iowa Code section 135.143.

“Indemnify” means the state of Iowa will pay all sums that a public health response team member is legally obligated to pay as damages because of any claim made against the public health response team member that arises out of the provision of direct medical care or other support services rendered or that should have been rendered during a disaster, threatened disaster, or other incident defined in Iowa Code section 135.143, or arising out of a training exercise to prepare for a disaster or other incident defined in Iowa Code section 135.143.

“Iowa mortuary operational response team” or *“IMORT”* means a public health response team that is sponsored and approved by the department to provide decedent care in the event of a mass fatality disaster or threatened disaster or other incident defined in Iowa Code section 135.143.

“Logistical support response team” or *“LSRT”* means a public health response team that is sponsored and approved by the department to provide logistical support and assistance in the event of a disaster or threatened disaster or other incident defined in Iowa Code section 135.143.

“Public health response team” or *“PHRT”* means a team of professionals, including licensed health care providers, nonmedical professionals skilled and trained in disaster or emergency response, and public health practitioners, that is sponsored and approved by the department to provide assistance in the event of a disaster or threatened disaster or other incident defined in Iowa Code section 135.143. “Public health response team” includes a disaster medical assistance team, an environmental health response team, a logistical support response team, the Iowa mortuary operational response team and other teams established and approved upon written order of the director to supplement and support disrupted or overburdened local medical and public health personnel, hospitals, and resources.

“Public health response team member” or *“PHRT member”* means an individual who has registered with the department and has received approval from the department to serve on a public health response team.

641—113.2(135) Public health response team members.

113.2(1) *Registration and approval.* An individual may apply to the department to be a public health response team member. The applicant shall apply on the Iowa statewide registry of volunteers (iSERV) website or on a form approved by the department and shall provide all requested information. The department will register and approve an individual to serve as a PHRT member when the department is satisfied that the individual satisfies the requirements of this chapter and will perform on a PHRT in compliance with Iowa Code section 135.143 and this chapter. Upon registration and approval of an individual, the department will provide the individual with written notification that the individual is registered with the department and has been approved to serve on a PHRT. The written notification will also include the effective date of the approval and the terms and conditions of approval.

113.2(2) *Denial and revocation.* The department may deny approval to an individual or may revoke an individual’s approval if the department determines the individual has violated or failed to

comply with Iowa Code section 135.143 or this chapter, any term or condition contained in the written approval notification from the department, any operational procedure, or state or federal law, or has exposed or may expose the state to undue risk. The department will notify the individual of the department's decision in writing by certified mail, return receipt requested. In the event an individual is dissatisfied with the department's decision, the individual may submit a request for reconsideration to the department. Such request shall be delivered by certified mail, return receipt requested, within 20 days of the date of the denial or revocation notification, to the department. The department will review the matter and issue a written decision within 20 days of receipt of the request. The department's decision shall be final agency action. This appeal process does not constitute a contested case proceeding as defined in Iowa Code chapter 17A.

113.2(3) *Effect of revocation.* If the department revokes a public health response team member's approval, the action may preclude future eligibility, but shall not negate defense and indemnification coverage or other protection for covered acts or omissions that occurred during the effective date of approval.

641—113.3(135) Public health response team.

113.3(1) *General requirements.*

- a. An individual may make application to be a member of a PHRT pursuant to subrule 113.2(1).
- b. The department will establish the Iowa Volunteer Public Health Response Team Operational Procedures Manual. The operational procedures will be in writing and will be provided to each PHRT member. All PHRT members shall follow the PHRT operational procedures as established by the department. The Iowa Volunteer Public Health Response Team Operational Procedures Manual is available from the department.
- c. If the department notifies a PHRT member of a violation of Iowa Code section 135.143, this chapter, or an operational procedure, the PHRT member shall correct the deficiency or violation identified by the department within a time frame determined by the department. If a PHRT member fails to correct a deficiency or violation within the time frame identified by the department, or if the deficiency or violation constitutes an immediate danger to the public health, safety, or welfare, the department may initiate action to revoke approval pursuant to subrule 113.2(2).

113.3(2) *Team composition.*

- a. A PHRT shall be comprised of health care professionals and administrative personnel as identified in the Iowa Volunteer Public Health Response Team Operational Procedures Manual.
- b. The department is responsible for maintaining adequate staffing.

113.3(3) *Licensure and educational requirements.*

- a. Each PHRT member shall hold and maintain an active unrestricted license, registration, or certification to practice in Iowa (if applicable) in the member's respective medical or health care profession.
- b. Each PHRT member shall complete required training as listed in the Iowa Volunteer Public Health Response Team Operational Procedures Manual, including training specified in respective team annexes.
- c. The department may provide specific position training to PHRT members as determined to be necessary.
- d. The department will develop and implement training exercises to test the team's notification process, deployment readiness, and response capabilities.
- e. The department is responsible for documenting each PHRT member's completion of required training.

113.3(4) *Deployment and standdown.*

- a. PHRTs shall prepare to deploy within two to four hours of notification by the department. PHRTs shall not self-deploy and shall not be covered by the provisions of Iowa Code section 135.143 and this chapter if the PHRTs self-deploy or are deployed by another agency or entity.

b. Deployment and standdown procedures are outlined in the Iowa Volunteer Public Health Response Team Operational Procedures Manual and shall be followed by all PHRT members.

641—113.4(135) Legal and other protections. A PHRT member acting pursuant to Iowa Code section 135.143 and this chapter shall be considered an employee of the state under Iowa Code section 29C.21 and chapter 669, shall be afforded protection as an employee of the state under Iowa Code section 669.21 whom the state shall defend and indemnify, and shall be considered an employee of the state for purposes of workers' compensation, disability, and death benefits, provided that the member has done all of the following:

1. Registered with and received approval from the department pursuant to subrule 113.2(1) to serve on a PHRT.
2. Provided direct medical care or other support services during a disaster, threatened disaster, or other incident described in Iowa Code section 135.143(1); or participated in a training exercise to prepare for a disaster or other incident described in Iowa Code section 135.143(1).

641—113.5(135) Reporting requirements and duties.

113.5(1) Upon obtaining knowledge or becoming aware of any injury allegedly arising out of the negligent rendering of, or the negligent failure to render, medical or other services as a PHRT member, the member shall provide written notice to the department, as soon as practicable, containing to the extent obtainable the circumstance of the alleged injury, the name and address of the injured, and any other relevant information.

113.5(2) Upon obtaining knowledge or becoming aware of any injury as defined in subrule 113.5(1), a PHRT member shall promptly take all reasonable steps to prevent further or additional injury from the same or similar circumstances, situations, or conditions.

113.5(3) A PHRT member shall immediately notify the office of the Iowa attorney general of service or receipt of an original petition, suit, or claim seeking damage from the PHRT member related to participation on a PHRT.

113.5(4) Each PHRT member shall fully cooperate with the state in the defense of any claim or suit related to participation on a PHRT, including attending hearings, depositions, and trials and assisting in securing and giving evidence, responding to discovery and ensuring the attendance of witnesses.

113.5(5) Each PHRT member shall accept financial responsibility for personal expenses and costs incurred in the defense of any claim or suit related to participation on a PHRT, including travel, meals, and compensation for time and lost practice.

These rules are intended to implement Iowa Code section 135.143.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 114
“Preparedness Advisory Council”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Executive Order 10
State or federal law(s) implemented by the rulemaking: Executive Order 10

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The committee described in this chapter is required to receive federal grant funds in the event of a public health disaster. The committee’s purpose, organization, and procedures are more appropriately outlined under a formal charter document. Therefore, the Department proposes to rescind the entire chapter.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated.
 - Classes of persons that will benefit from the proposed rulemaking:
None, but none are harmed, either.
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:
Repealing eight administrative rules.
 - Qualitative description of impact:
None; the committee will continue under a formal charter.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
None.
 - Anticipated effect on state revenues:

None.

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

Not applicable; repealing the chapter is the correct action to take.

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:

None.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 114**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 122
“Anatomical Gift Public Awareness and Transplantation Fund”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Executive Order 10
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 142C

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This chapter is intended to provide clarification of expectations of the disbursement of anatomical gift funds, which are from monies donated through the vehicle registration process. This chapter is proposed to be rescinded.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None were identified.
 - Classes of persons that will benefit from the proposed rulemaking:
None were identified.
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:
None were identified; the chapter is being rescinded.
 - Qualitative description of impact:
Eliminating unnecessary regulation.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
None were identified.
 - Anticipated effect on state revenues:
There is no effect.

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

Not applicable; the chapter is being rescinded.

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

No. Rescinding the chapter is the correct action to take as there is no specific statutory authority for the rulemaking.

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 rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 122**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 124
“Interagency Coordinating Council for the State Medical Examiner”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 691.6B

State or federal law(s) implemented by the rulemaking: 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 12, 2024
1 p.m.

Microsoft Teams
Meeting ID: 287 138 322 978
Passcode: w3jvk8

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:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking implements, in part, 2024 Iowa Acts, Senate File 2385, section 368, which directs the repeal of Iowa Code section 691.6B, which describes the Interagency Coordinating Council. Chapter 124 is the chapter that describes the Interagency Coordinating Council of the State Medical Examiner.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
None, though none are harmed.
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:
Rescinding and reserving one administrative rule chapter.
 - Qualitative description of impact:
Eliminating reference to a council that no longer exists by law.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

There are no costs associated with this rulemaking.

- Anticipated effect on state revenues:

There is no impact on state revenues.

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

Rulemaking to rescind and reserve the chapter is appropriate since there is no longer authority for the rules to exist.

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

Rescinding the chapter is both appropriate and required.

6. Alternative methods considered by the agency:

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

None were seriously considered.

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

Rulemaking to rescind and reserve the chapter is appropriate since there is no longer authority for rules to exist.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 124**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 130
“Emergency Medical Services Advisory Council”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Not applicable
State or federal law(s) implemented by the rulemaking: Executive Order 10 and 2024 Iowa Acts,
Senate File 2385

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed rulemaking is to rescind a chapter eliminated in the 2024 Legislative Session.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
No class of persons will specifically benefit; however, neither are any persons harmed by the rulemaking.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
Eliminating an entire administrative chapter consisting of eight administrative rules.
 - Qualitative description of impact:
Eliminating a regulatory body pursuant to new legislation.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
None.
 - Anticipated effect on state revenues:

None.

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

Not applicable.

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

No. Repealing the chapter is both appropriate and required.

6. Alternative methods considered by the agency:

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

None.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 130**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 131

“Emergency Medical Services—Providers—Initial Certification—Renewal and Reactivation—
Authority—Complaints and Investigations”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.4

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147A, 147D, and 272C

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter establishes the regulations and requirements for emergency medical provider initial certification for individuals who have been trained to provide emergency and nonemergency medical care at the emergency medical responder (EMR), emergency medical technician (EMT), advanced emergency medical technicians (AEMT), paramedic or other certification level recognized by the Department; describes the authority, permission to practice and scope of practice for certified emergency medical care providers in the state of Iowa; and establishes the regulations and requirements for renewal, extension and reactivation of an emergency medical care provider certification in the state of Iowa.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Emergency medical services (EMS) providers pay the application and renewal costs associated with their certification.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who require the services of EMS providers will benefit.
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:

There are approximately 10,710 EMS providers certified in the state of Iowa. Providers recertify every two years. Application and renewal fees are paid by prospective and current EMS providers. There is no fee incurred for renewal of certification for the EMR or EMT level. There is a \$10 renewal fee for the AEMT level. There is a \$25 renewal fee for the paramedic level. Initial certification and reactivation of certification in Iowa is \$30. The bureau is removing the \$50 fee for background checks because this process is moving to an outside entity.

- Qualitative description of impact:

The rulemaking helps ensure that EMS providers are maintaining the appropriate qualifications and standards to provide the best care to Iowans in need.

3. Costs to the State:

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

The Department supports 3.5 full-time equivalent (FTE) positions in the direct and indirect work of provider certification. One administrative assistant, 0.5 EMS program planner, one compliance officer, and one EMS program director. Cost to state general funds for FTE positions is \$432,386.

- Anticipated effect on state revenues:

Fees are retained to offset some minimal administrative costs associated with application processing. There will be a decrease in retained funds due to the removal of the background check fee.

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

Not having appropriate certification standards for EMS providers could cause the overall level of care provided to decline, putting Iowans who require those services at risk for harm.

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

No, the rulemaking is appropriate and required by law.

6. Alternative methods considered by the agency:

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

No other alternative methods were seriously considered by the Department.

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

Rulemaking is appropriate and required by law.

Small Business Impact

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

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

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

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 131 and adopt the following **new** chapter in lieu thereof:

CHAPTER 131
EMERGENCY MEDICAL SERVICES—PROVIDERS—INITIAL CERTIFICATION—
RENEWAL AND REACTIVATION—AUTHORITY—COMPLAINTS AND
INVESTIGATIONS

641—131.1(147A,147D,272C) Definitions. For the purpose of these rules, the following definitions apply:

“Advanced emergency medical technician” or *“AEMT”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the Department or NREMT testing requirements for the AEMT, and is currently certified by the department as an AEMT.

“CAPCE” means the Commission on Accreditation for Prehospital Continuing Education, the accrediting body charged with the review and accreditation of EMS continuing education.

“CEH” means continuing education hour, which is based upon a minimum of 50 minutes of training per hour.

“Certification” or *“certificate”* means a document issued by the department authorizing a person to practice as an emergency medical care provider in Iowa.

“Certification period” means the length of time an emergency medical care provider certificate is valid. The certification period is two years from initial issuance or from renewal unless otherwise specified on the certificate or unless sooner suspended or revoked.

“Certification status” means the status of an individual EMS certificate holder.

1. *“Active”* means the holder of the certification has the authority to function as an emergency medical care provider at the level certified in accordance with subrule 131.4(1).

2. *“Probation,”* which is an active certification, means the holder of the certification has the authority to function as an emergency medical care provider at the level certified in accordance with subrule 131.4(1) and under the conditions of probation.

3. *“Denied”* means the certificate is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

4. *“Inactive”* means the certificate is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

5. *“Revoked”* means the certification is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

6. *“Surrendered”* means the certification is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

7. *“Suspended”* means the certification is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

“Certified” means being officially recognized as meeting department-approved testing and training standards and being issued a certificate by the department in accordance with Iowa Code chapters 272C and 147A to practice as an emergency medical care provider in the state of Iowa.

“Compact” means the emergency medical services personnel licensure interstate compact according to Iowa Code chapter 147D.

“Complete criminal record” includes the complaint and judgment of conviction for each offense of which the applicant has been convicted, regardless of whether the offense is classified as a felony or a misdemeanor, and regardless of the jurisdiction in which the offense occurred.

“Conviction” means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. *“Conviction”* includes Alford pleas and pleas of nolo contendere.

“Core continuing education” means education obtained during a certification period to renew certification. Core continuing education will have an assigned sponsor number from CAPCE, an authorized EMS training program, the board of nursing, the board of medicine or the department.

“Critical care paramedic” or *“CCP”* means a currently certified paramedic who has successfully completed a critical care course of instruction approved by the department and has received endorsement from the department as a critical care paramedic.

“Disqualifying offense” means a conviction directly related to the duties and responsibilities of the profession. A conviction is directly related to the duties and responsibilities of the profession if either (1) the actions taken in furtherance of an offense are actions customarily performed within the scope of practice of a certified profession, or (2) the circumstances under which an offense was committed are circumstances customary to a certified profession.

“Emergency medical care” means any medical procedure authorized by Iowa Code chapter 147A and these rules.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“Emergency medical care student” means an individual registered with the department and enrolled in an EMS training program with an active EMS student registration.

“Emergency medical responder” or *“EMR”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the EMR, and is currently certified by the department as an EMR.

“Emergency medical services” or *“EMS”* means an integrated medical care delivery system to provide emergency and nonemergency medical care at the scene or during out-of-hospital patient transportation in an ambulance.

“Emergency medical technician” or *“EMT”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the EMT, and is currently certified by the department as an EMT.

“Emergency medical technician-defibrillation” or *“EMT-D”* means an individual who has successfully completed an approved program and is currently certified by the department as an EMT-D.

“EMS clinical guidelines” or *“minimum EMS clinical guidelines”* means a minimum clinical standard approved by the department upon which a service program’s medical director will base service program protocols.

“EMS instructor” or *“EMS-I”* means an individual who has successfully completed an EMS instructor curriculum approved by the department and is currently endorsed by the department as an EMS-I.

“Endorsement” or *“endorsed”* means an approval granted by the department authorizing an individual to serve as an EMS-I or CCP.

“Fees” means those fees received pursuant to Iowa Code chapters 147A and 147D.

“First responder” or *“FR”* means an individual who has successfully completed an approved program and is currently certified by the department as an FR.

“First responder-defibrillation” or *“FR-D”* means an individual who has successfully completed an approved program and is currently certified by the department as an FR-D.

“NREMT” means the National Registry of Emergency Medical Technicians. The NREMT provides a valid, uniform process to assess the knowledge and skills required for competent practice by EMS professionals.

“Paramedic” or *“PM”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the paramedic, and is currently certified by the department as a paramedic.

“Patient” means an individual who is sick, injured, or otherwise incapacitated and has been evaluated or provided treatment by an emergency medical care provider.

“Patient abandonment” means a termination of the provider/patient relationship at a time when a continuous level of care is needed. Patient abandonment does not occur when a scene is unsecured, deteriorates or becomes too dangerous for the emergency medical care provider to safely function. Patient abandonment does not occur when patient care is transferred to another emergency medical care provider following assessment or triage.

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician assistant” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Protocols” means written directions and orders approved by a service program’s medical director utilizing the EMS clinical guidelines.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Service program” or *“service”* means any transport service or nontransport service, inclusive of associated satellites and service program affiliates, that has received full or conditional authorization from the department.

641—131.2(147A,272C) Initial certification.

131.2(1) An individual who has successfully completed the training program requirements at the EMR, EMT, AEMT or paramedic level and has a valid certification with NREMT shall submit the following to the department for initial Iowa emergency medical care provider certification:

- a. A completed EMS certification application.
- b. An NREMT active certification number.
- c. Payment of the initial application fee.
- d. Two completed fingerprint cards for background checks.
- e. Payment of the background check fee.

131.2(2) The individual seeking an Iowa emergency medical provider care certification shall submit all application materials within two years from the Iowa training program course completion date.

131.2(3) If the individual is unable to complete the requirements within two years due to medical reasons or military obligation, an extension may be granted upon submission of a signed statement from an appropriate medical or military authority and approval by the department.

131.2(4) Fees may be waived in accordance with provisions in Iowa Code chapter 272C.

131.2(5) Use of criminal convictions in eligibility determinations and initial licensing decisions.

a. *License application.* Unless an applicant for licensure petitions the department for an eligibility determination pursuant to paragraph 131.2(7) “b,” the applicant’s convictions will be reviewed when the department receives a completed license application.

(1) An applicant must disclose all convictions on a license application. Failure to disclose all convictions is grounds for license denial or disciplinary action following license issuance.

(2) An applicant with one or more convictions shall submit the complete criminal record for each conviction and a personal statement regarding whether each conviction directly relates to the practice of the profession in order for the license application to be considered complete.

(3) An applicant must submit as a part of the license application all evidence of rehabilitation that the applicant wishes to be considered by the department.

(4) The board may deny a license if the applicant has a disqualifying offense unless the applicant demonstrates by clear and convincing evidence that the applicant is rehabilitated pursuant to Iowa Code section 272C.15.

(5) An applicant with one or more disqualifying offenses who has been found rehabilitated must still satisfy all other requirements for licensure.

(6) Any application fees paid will not be refunded if the license is denied.

b. *Eligibility determination.* An individual who has not yet submitted a completed license application may petition the department for a determination of whether one or more of the individual’s

convictions are disqualifying offenses that would render the individual ineligible for licensure. An individual with a conviction is not required to petition the department for an eligibility determination prior to applying for licensure. To petition the department for an eligibility determination of whether one or more of the petitioner's convictions are disqualifying offenses, a petitioner shall submit all of the following:

- (1) A completed petition for eligibility determination form;
- (2) The complete criminal record for each of the petitioner's convictions;
- (3) A personal statement regarding whether each conviction directly relates to the duties and responsibilities of the profession and why the department should find the petitioner rehabilitated;
- (4) All evidence of rehabilitation that the petitioner wishes to be considered by the board; and
- (5) Payment of a nonrefundable fee of \$25.

c. Appeal. A petitioner deemed ineligible or an applicant denied a license because of a disqualifying offense may appeal the decision in the manner and time frame set forth in the department's written decision. A timely appeal will initiate a nondisciplinary contested case proceeding. The department's rules governing contested case proceedings will apply unless otherwise specified in this rule. If the petitioner or applicant fails to timely appeal, the department's written decision will become a final order.

(1) An administrative law judge will serve as the presiding officer of the nondisciplinary contested case proceeding unless the department elects to serve as the presiding officer. When an administrative law judge serves as the presiding officer, the decision rendered is a proposed decision.

(2) The contested case hearing will be closed to the public and the department's review of a proposed decision will occur in closed session.

(3) The office of the attorney general will represent the department's initial ineligibility determination or license denial and has the burden of proof to establish that the petitioner or applicant's convictions include at least one disqualifying offense. Upon satisfaction of this burden by a preponderance of the evidence by the office of the attorney general, the burden of proof shifts to the petitioner or applicant to establish rehabilitation by clear and convincing evidence.

(4) A petitioner or applicant must appeal an ineligibility determination or license denial in order to exhaust administrative remedies. A petitioner or applicant may only seek judicial review of an ineligibility determination or license denial after the issuance of a final order following a contested case proceeding. Judicial review of the final order following a contested case proceeding shall be in accordance with Iowa Code chapter 17A.

d. Future petitions or applications. If a final order determines a petitioner is ineligible, the petitioner may not submit a subsequent petition for eligibility determination or a license application prior to the date specified in the final order. If a final order denies a license application, the applicant may not submit a subsequent license application or a petition for eligibility determination prior to the date specified in the final order.

641—131.3(147A) Background check results. All criminal history records are confidential and will only be used in accordance with this policy to determine eligibility. All background check records will be stored in a secure location. Background check records will not be redisseminated by the department.

641—131.4(147A) Authority.

131.4(1) *Authority of emergency medical care provider.* An emergency medical care provider who holds an active Iowa certification issued by the department or has permission to practice in Iowa pursuant to Iowa Code chapter 147D may:

a. As a member of a responding authorized service program, render emergency medical care and perform emergency medical care without contacting medical direction if written protocols have been approved by the service program medical director.

b. Function in any hospital or any other entity in which health care is ordinarily provided only when:

(1) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided when under the direct supervision of a physician as a member of an authorized service program, or in an individual capacity, by rendering lifesaving services in the facility in which employed or assigned pursuant to the emergency medical care provider's certification and under direct supervision of a physician, physician assistant, or registered nurse. An emergency medical care provider shall not routinely function without the direct supervision of a physician, physician assistant, or registered nurse. However, when the physician, physician assistant, or registered nurse cannot directly assume emergency care of the patient, the emergency medical care provider may perform, without direct supervision, emergency medical care procedures for which certified, if the life of the patient is in immediate danger and such care is required to preserve the patient's life;

(2) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided when under the direct supervision of a physician, as a member of an authorized service program, or in an individual capacity, to perform nonlifesaving procedures for which certified and designated in a written job description. Such procedures may be performed after the patient is observed by and when the emergency medical care provider is under the supervision of the physician, physician assistant, or registered nurse and where the procedure may be immediately abandoned without risk to the patient.

131.4(2) *Scope of practice.*

a. Emergency medical care providers shall perform only those skills and procedures that are authorized within the scope of practice for which an emergency medical care provider is certified.

b. The Iowa Emergency Medical Care Provider Scope of Practice (September 2019) is hereby incorporated and adopted by reference for emergency medical care providers. For any differences that may occur between the scope of practice adopted by reference and these rules, the rules prevail.

c. The Iowa Emergency Medical Care Provider Scope of Practice (September 2019) is available on the department's website.

d. The department may grant a waiver for changes to the scope of practice that have not yet been adopted by reference in these rules pursuant to 441—Chapter 6.

641—131.5(147A) Renewal standards, reactivation procedures, fees, and continuing education.

131.5(1) *Renewal of certification.*

a. An emergency medical care provider shall submit an application for renewal of an active Iowa EMS certification within 90 days prior to the certification expiration date.

b. The renewal application and process are completed online via an individual Iowa EMS provider account. The electronic portal to access individual accounts may be accessed through the department's website.

c. Renewal notifications will be sent to Iowa emergency medical care providers who have an active certification set to expire in 90 days. The notification will be sent by email to the address on file in the emergency medical care provider's electronic profile.

d. It is the emergency medical care provider's responsibility to ensure the electronic profile information, including the email address, is updated and correct within 30 days of any change.

e. A renewal certificate is valid for two years from the current expiration date unless sooner surrendered, suspended or revoked.

f. A lower-level certificate may be renewed if the individual voluntarily chooses to move from a higher level to a lower level by completing all applicable continuing education requirements for the lower level during the certification period and submitting a change of status request, available from the department upon request.

g. A certification status becomes inactive if the certificate has not been renewed by the certification expiration date unless the emergency medical care provider is granted an extension as described in subrule 131.5(3).

h. An emergency medical care provider may request an inactive status. The request must be made by submitting a change of status request, available from the department upon request. A request for inactive status, when accepted in connection with a disciplinary investigation or proceeding, has the same effect as an order of revocation.

131.5(2) *Late renewal of certification.*

a. An emergency medical care provider who has completed the required continuing education during the certification period but fails to submit the EMS renewal of certification application and applicable fees prior to the certification expiration date is eligible for late renewal of the inactive certification.

b. The emergency medical care provider shall complete the EMS renewal of certification application, submit a late fee in addition to the applicable renewal fee and submit an audit report form provided by the department. The fee and audit report form shall be submitted before the last day of the month following the certification expiration date. If the late renewal submission is not completed by the last day of the month following the certification expiration date, the certification remains inactive.

c. An emergency medical care provider who has not completed the required continuing education during the certification period is not eligible for late renewal. The certification is inactive.

131.5(3) *Extension of certification.*

a. An emergency medical care provider who is unable to attain all continuing education requirements within the certification period may request a 45-day extension. To complete the extension process, the provider shall:

(1) Submit a request for extension application, available from the department upon request, at least 7 days prior to the certification expiration date, but no more than 90 days prior to the certification expiration date, and payment of the extension fee.

(2) Complete the continuing education requirements.

(3) Complete and submit the EMS affirmative renewal of certification application, with all applicable renewal fees, to the department prior to the extended expiration date.

(4) Submit an audit report form provided by the department.

b. If an emergency medical care provider fails to submit any of the items required in subparagraphs 131.5(3)“a”(2) and (3) by the 45th day of the extended certification period, the certification will be inactive.

c. The emergency medical care provider may not use continuing education completed during the extension period in the subsequent renewal period.

131.5(4) *Reactivation of an inactive certification.*

a. Certification inactive up to 24 months. An emergency medical care provider may apply to reactivate an inactive certification up to 24 months after the certification became inactive.

(1) An individual will submit to the department an EMS certification reactivation application, which is available from the department upon request.

(2) If the department approves the application, the individual must submit an audit report form with 36 core continuing education hours prorated per lapsed year by core topic area and the reactivation fee.

(3) Upon receipt and approval of the items required in subparagraphs 131.5(4)“a”(1) and (2), the department may issue a new certification.

(4) An emergency medical care provider who fails to complete the reactivation process within 12 months from the date of application approval must reapply for reactivation of the inactive certification.

b. Certification inactive from 25 months to 48 months. An emergency medical care provider may apply to reactivate an inactive certification that has been inactive for 25 months but no more than 48 months.

(1) An individual will submit to the department an EMS certification reactivation application, which is available from the department upon request.

(2) If the department approves the application, the individual must submit documentation of successful completion of an approved EMS refresher course that includes successful completion of department or NREMT testing requirements. In addition, the individual must:

1. Complete fingerprint requirements.
2. Submit reactivation and background check fees.
3. Upon receipt and approval of the items required in subparagraphs 131.5(4)“b”(1) and (2), the department may issue a new certification.
4. An emergency medical care provider who fails to complete the reactivation process within 12 months from the date of application approval must reapply for reactivation of the inactive certification.

c. Certification inactive for more than 48 months. An emergency medical care provider may not apply to reactivate a certification that has been inactive for more than 48 months.

131.5(5) *Reactivation of revoked or suspended certification.*

a. Any person whose certification to practice has been revoked or suspended may apply to the department for reactivation in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the certification is permanently revoked.

b. If the order of revocation or suspension did not establish terms and conditions upon which reactivation might occur or if the certification was voluntarily surrendered, an initial application for reactivation may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender.

c. All proceedings for reactivation shall be initiated by the person whose certification has been revoked or suspended in accordance with subrule 131.5(4). An application for reactivation shall allege facts that, if established, will be sufficient to enable the department to determine that the basis for the revocation or suspension of the person’s certification no longer exists and that it will be in the public interest for the certification to be reinstated. The burden of proof to establish such facts is on the person whose certification has been suspended or revoked.

d. An order denying or granting reactivation shall be based upon a decision that incorporates findings of facts and conclusions of law.

131.5(6) *Fees.* The nonrefundable fees are as follows:

- a.* Application for initial Iowa certification at all certification levels: \$30.
- b.* Reactivation of a certification to practice: \$30.
- c.* Renewal of a certification to practice as a first responder, EMR: no fee.
- d.* Renewal of a certification to practice as an EMT: no fee.
- e.* Renewal of a certification to practice as an AEMT: \$10.
- f.* Renewal of a certification to practice as a paramedic: \$25.
- g.* Late renewal of a certification to practice: \$30.
- h.* Returned payment due to insufficient funds: \$15.
- i.* Extension of certification: \$50.

131.5(7) *Continuing education renewal.*

a. The table below illustrates the minimum number of core continuing education hours (CEHs) by topic area for each level of emergency medical care provider to renew an Iowa EMS certification.

Core Topics	EMR/FR	EMT/EMT-D	AEMT	PM
Airway, Respirations, Ventilations	1	1	2	3
Cardiology	2	6	7	9
Trauma	1	2	3	3
Medical	3	6	8	9
Operations	1	5	5	6
Totals	8	20	25	30

b. All core continuing education hours used to renew an Iowa EMS certification must have a sponsor number by an authorized Iowa training program, the department, the board of nursing, the board of medicine, or CAPCE before the emergency medical care provider attends the offering.

c. An emergency medical care provider who is registered with the NREMT may renew the provider's Iowa EMS certification by meeting the NREMT's requirements. The emergency medical care provider must submit the Iowa affirmative renewal of certification application and all appropriate fees.

d. An emergency medical care provider is deemed to have complied with the continuing education requirements during periods in which the provider serves honorably on active duty in the military services or for periods in which the provider is a government employee working as an emergency medical care provider and assigned to duty outside the United States. The emergency medical care provider must submit the Iowa affirmative renewal of certification application, all appropriate fees and documentation of assignment.

e. The emergency medical care provider must maintain a file containing documentation of CEHs accrued during each certification period for four years from the end of each certification period.

f. A group of emergency medical care providers will be audited for each certification period. Emergency medical care providers to be audited will be chosen in a random manner or at the discretion of the department. Falsifying reports or failure to comply with the audit request may result in formal disciplinary action. Those audited must submit a department-provided audit report form within 45 days of the request. If audited, the emergency medical care provider must provide the following information:

- (1) Date of program.
- (2) Program sponsor number.
- (3) Title of program.
- (4) Number of approved hours.

131.5(8) Continuing education approval. The following standards apply for approval of continuing education:

a. CEHs will have an assigned sponsor number from CAPCE, an authorized EMS training program, the board of nursing, the board of medicine or the department.

b. Human health-related college courses may be approved in advance by the department at one quarter credit equal to 10 CEHs, one semester credit equal to 15 CEHs.

131.5(9) Out-of-state continuing education. Out-of-state continuing education courses will be accepted for CEHs if all criteria in subrule 131.5(7) are met and if the courses have been approved for emergency medical care personnel in the state in which the courses were held. A copy of course completion certificates (or other verifying documentation) shall, upon request, be submitted to the department.

641—131.6(147A,272C) Discipline—denial, citation and warning, probation, suspension, or revocation of certificates or renewal.

131.6(1) This rule is not subject to waiver pursuant to 441—Chapter 6 or any other provision of law.

131.6(2) Prohibited grounds for discipline. The department will not suspend or revoke the certification of a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

131.6(3) Methods of discipline.

a. The department has the authority to impose the following disciplinary sanctions against an emergency medical care provider:

- (1) Issue a citation and warning.
- (2) Impose a civil penalty not to exceed \$1,000.
- (3) Require reexamination.

- (4) Require additional education or training.
- (5) Impose a period of probation under specific conditions.
- (6) Prohibit permanently, until further order of the department, or for a specific period, a provider's ability to engage in specific procedures, methods, acts or activities incident to the practice of the profession.

- (7) Suspend a certificate until further order of the department or for a specific period.

- (8) Deny an application for certification.

- (9) Revoke a certification.

- (10) Impose such other sanctions as allowed by law and as may be appropriate.

- b.* A request for inactive status in connection with a disciplinary investigation or proceeding has the same effect as an order of revocation.

- c.* A citation and warning, denial, probation, restriction, suspension, revocation, or civil penalty imposed upon an individual certificate holder by the department will be considered applicable to all certificates and endorsements issued to that individual by the department.

- d.* An emergency medical care provider who has knowledge of an emergency medical care provider, service program or training program that has violated Iowa Code chapter 147A or these rules shall report such information to the department within 30 days.

131.6(4) The department may deny an application for issuance or renewal of an emergency medical care provider certificate, including endorsement, or may impose any of the disciplinary sanctions provided in subrule 131.6(3) when it finds that the individual or certificate holder has committed any of the following acts or offenses:

- a.* Negligence in performing emergency medical care.

- b.* Failure to follow the directions of supervising physicians or their designees.

- c.* Rendering treatment not authorized under Iowa Code chapter 147A.

- d.* Patient abandonment.

- e.* Fraud in procuring certification or renewal, including but not limited to:

- (1) An intentional perversion of the truth in making application for a certification to practice in this state;

- (2) False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a certification in this state; or

- (3) Attempting to file or filing with the department or training program any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a certification in this state.

- f.* Professional incompetency. Professional incompetency includes but is not limited to:

- (1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

- (2) A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other emergency medical care providers in the state of Iowa acting in the same or similar circumstances.

- (3) A failure to exercise the degree of care that is ordinarily exercised by the average emergency medical care provider acting in the same or similar circumstances.

- (4) Failure to conform to the minimal standard of acceptable and prevailing practice of certified emergency medical care providers in this state.

- (5) A substantial lack of knowledge or ability to discharge professional obligations within the minimum clinical standards approved by the department.

- g.* Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established. Acts that may constitute unethical conduct include but are not limited to:

(1) Verbally or physically abusing a patient, coworker or any other individual encountered while a certified emergency medical care provider.

(2) Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient, coworker or any other individual encountered while certified as an emergency medical care provider in the state of Iowa.

(3) Betrayal of a professional confidence.

(4) Engaging in a professional conflict of interest.

(5) Falsification of medical records, official documents or other writings or records.

h. Engaging in any conduct that subverts or attempts to subvert a department investigation.

i. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.

j. Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.

k. Failure to report another emergency medical care provider to the department for any violations listed in these rules pursuant to Iowa Code chapter 147A.

l. Knowingly aiding, assisting or advising a person to unlawfully practice EMS.

m. Representing oneself as an emergency medical care provider when one's certification has been suspended or revoked or when one's certification is lapsed or has been placed on inactive status.

n. Permitting the use of a certification by a noncertified person for any purpose.

o. Mental or physical inability reasonably related to and adversely affecting the emergency medical care provider's ability to practice in a safe and competent manner as determined by an evaluation from a licensed evaluator of the provider's mental or physical status.

p. Being adjudged mentally incompetent by a court of competent jurisdiction.

q. Sexual harassment of a patient, student, coworker or any other individual encountered while certified as an emergency medical care provider in the state of Iowa. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature communicated in person, in writing, via a third person or through electronic communication.

r. Habitual intoxication or addiction to drugs.

(1) The inability of an emergency medical care provider to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

(2) The excessive use of drugs that may impair an emergency medical care provider's ability to practice with reasonable skill or safety.

(3) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

s. Fraud in representation as to skill, ability or certification.

t. Willful or repeated violations of Iowa Code chapter 147A or these rules.

u. Conviction of a disqualifying offense. A copy of the guilty plea or order of conviction constitutes conclusive evidence of conviction.

v. Having certification to practice emergency medical care suspended or revoked or having other disciplinary action taken by a licensing or certifying authority of this state or another state, territory or country. A copy of the record or order of suspension, revocation or disciplinary action is conclusive or prima facie evidence.

w. Falsifying certification renewal reports or failure to comply with the renewal audit request.

x. Acceptance of any fee by fraud or misrepresentation.

y. Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

z. Violating privacy and confidentiality. An emergency medical care provider shall not disclose or be compelled to disclose patient information unless disclosure is required or authorized by law.

aa. Discrimination. An emergency medical care provider shall not practice, condone, or facilitate discrimination against a patient, student, or any other individual encountered while acting as certified as an emergency medical care provider in the state of Iowa on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability, diagnosis, or social or economic status.

ab. Practicing emergency medical services or using a designation of certification or otherwise holding oneself out as practicing emergency medical services at a certain level of certification when the emergency medical care provider is not certified at such level.

ac. Failure to respond within 30 days of receipt, unless otherwise specified, to communication from the department that was sent by registered or certified mail.

641—131.7(147A) Certification denial.

131.7(1) An individual who has been denied certification by the department may appeal the denial and request a hearing on the issues related to the licensure denial by serving a notice of appeal and request for hearing upon the department not more than 20 days following the date of mailing of the notification of certification denial to the individual. The request for hearing shall specifically delineate the facts to be contested at hearing.

131.7(2) All hearings held pursuant to this rule will be held pursuant to the process outlined in this chapter.

641—131.8(147A) Emergency adjudicative proceedings. To the extent necessary to prevent or avoid immediate danger to the public health, safety or welfare and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a certificate in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

131.8(1) Before issuing an emergency adjudicative order, the department will consider factors, including but not limited to the following:

a. Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

b. Whether the specific circumstances that pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the individual required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

e. Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

131.8(2) Issuance of order.

a. An emergency adjudicative order will contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

b. The written emergency adjudicative order will be immediately delivered to the individual who is required to comply with the order. Delivery will be made by one or more of the following procedures:

(1) Personal delivery.

(2) Certified mail, return receipt requested, to the last address on file with the department.

(3) Fax. Fax may be used as the sole method of delivery if the individual required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the department will select the procedure for providing written notice that best ensures prompt, reliable delivery.

d. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department will make reasonable immediate efforts to contact by telephone the individual who is required to comply with the order.

e. After the issuance of an emergency adjudicative order, the department will proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

f. Issuance of a written emergency adjudicative order will include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the individual who is required to comply with the order is the party requesting the continuance.

641—131.9(147A) Complaints, investigations and appeals.

131.9(1) This rule is not subject to waiver pursuant to 441—Chapter 6 or any other provision of law.

131.9(2) All complaints regarding emergency medical care personnel, training programs or continuing education providers, or those purporting to be or operating as the same shall be reported to the department in writing.

131.9(3) An emergency medical care provider who has knowledge of an emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall report such information to the department.

131.9(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

131.9(5) A determination of mental incompetence by a court of competent jurisdiction automatically suspends a certificate for the duration of the certificate unless the department orders otherwise.

131.9(6) Notice of denial, issuance of a citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the alleged violator of denial, probation, suspension or revocation shall be served by certified mail, return receipt requested, or by personal service.

131.9(7) Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice to take action. If the request is made within the 20-day time period, the notice to take action is deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation becomes the department's final agency action.

131.9(8) Upon receipt of a request for hearing, the department will forward the request within five working days to the department of inspections, appeals, and licensing pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information that may be provided by the aggrieved party shall also be provided to the department of inspections, appeals, and licensing.

131.9(9) The hearing will be conducted according to the procedural rules of the department of inspections, appeals, and licensing found in 481—Chapter 10.

131.9(10) When the administrative law judge makes a proposed decision and order, it will be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then become the department's final agency action without further proceedings ten

days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 131.9(11).

131.9(11) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

131.9(12) Upon receipt of an appeal request, the administrative law judge will prepare the record of the hearing for submission to the director. The record will include the following:

- a.* All pleadings, motions, and rules.
- b.* All evidence received or considered and all other submissions by recording or transcript.
- c.* A statement of all matters officially noticed.
- d.* All questions and offers of proof, objections and rulings on them.
- e.* All proposed findings and exceptions.
- f.* The proposed decision and order of the administrative law judge.

131.9(13) The decision and order of the director become the department's final agency action upon receipt by the aggrieved party and will be delivered by certified mail, return receipt requested, or by personal service.

131.9(14) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

131.9(15) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order become final. A copy of the notice of appeal will be sent to the department by certified mail, return receipt requested, or by personal service.

131.9(16) The party who appeals a final agency action to the district court will pay the cost of the preparation of a transcript of the contested case hearing for the district court.

131.9(17) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, the news media or employer.

These rules are intended to implement Iowa Code chapters 147A and 147D and section 272C.4.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 132
“Emergency Medical Services—Service Program Authorization”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.4

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 147A, 147D, and 272C and section 321.231; 49 CFR 396; and 2024 Iowa Acts, House File 2507

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter provides clarity and creates a process for Emergency Medical Services (EMS) service program authorization.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who utilize EMS programs will benefit.
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:
There are 729 authorized EMS service programs in Iowa that serve 896 locations. There are over 450,000 patient encounters by EMS service programs per year.
 - Qualitative description of impact:
These rules outline defined service program processes and service program authorization, setting a minimum standard for the health and safety of Iowans who access the EMS system.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
Personnel and other administrative costs will be borne by the Department.

- Anticipated effect on state revenues:

There is no impact on state revenues.

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

Without the rules, there would be no standards for EMS programs and Iowans needing services could potentially receive substandard care, resulting in harm.

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

Rulemaking is both appropriate and required by law.

6. Alternative methods considered by the agency:

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

None were seriously considered.

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

Rulemaking is both appropriate and required by law.

Small Business Impact

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

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.

- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.

- Establish performance standards to replace design or operational standards in the rulemaking for small business.

- Exempt small business from any or all requirements of the rulemaking.

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

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 132 and adopt the following new chapter in lieu thereof:

CHAPTER 132

EMERGENCY MEDICAL SERVICES—SERVICE PROGRAM AUTHORIZATION

641—132.1(147A) Definitions. For the purpose of these rules, the following definitions apply:

“Advanced emergency medical technician level service” or “AEMT level service” means a service program that provides emergency medical care that does not exceed the scope of practice of a certified AEMT provider as outlined in 641—subrule 131.5(2).

“Advanced registered nurse practitioner” or “ARNP” means a nurse licensed pursuant to 655—7.1(152) with current licensure as a registered nurse in Iowa who is registered in Iowa to practice in an advanced role.

“Ambulance” means any privately or publicly owned ground, fixed wing or rotor wing vehicle equipped with life-support systems and specifically designed to transport the sick or injured who require emergency medical care.

“Applicant” means an owner of a transport or nontransport program or service program that is applying to the department for authorization as a service program or renewal of current authorization as a service program.

“Biomedical hazardous waste” means waste product that may be contaminated with a biological material that is an infectious disease transmission risk.

“Communication system” means but is not limited to a telecommunication system, radio communication system, or mobile data communication system.

“Conditional service level authorization” means an enhanced service program authorization under which a service program may provide an advanced level of service from that routinely provided under the service program’s full authorization level, on an intermittent basis with department and medical director approval.

“Continuous quality improvement” or *“CQI”* means a program that is an ongoing process to monitor standards at all EMS operational levels.

“Credentialing” means a clinical determination that is the responsibility of a physician medical director. It is the employer or affiliating organization’s responsibility to act on the clinical credentialing status of EMS personnel in making employment or deployment decisions.

“Critical care transport” or *“CCT”* means a paramedic level service program that has received an endorsement from the department to provide specialty care patient transportation and that is staffed by one or more paramedics with a critical care paramedic endorsement from the department or that is staffed by other health care professionals in an appropriate specialty area.

“Deficiency” means noncompliance with Iowa Code chapter 147A or these administrative rules.

“Emergency medical care” means any medical procedure authorized by Iowa Code chapter 147A and 641—Chapter 131.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“Emergency medical responder level service” or *“EMR level service”* means a nontransport service program that provides emergency medical care that does not exceed the scope of practice of a certified EMR provider as outlined in 641—subrule 131.5(2).

“Emergency medical services” or *“EMS”* means the same as defined in Iowa Code section 147A.1.

“Emergency medical technician-basic” or *“EMT-B”* means an individual who has successfully completed the current U.S. Department of Transportation’s Emergency Medical Technician-Basic curriculum and department enhancements, has passed the department’s approved written and practical examinations, and is currently certified by the department as an EMT-B.

“Emergency medical technician level service” or *“EMT level service”* means a service program that provides emergency medical care that does not exceed the scope of practice of a certified EMT provider as outlined in 641—subrule 131.5(2).

“Emergency medical transportation” means transportation of a patient by an ambulance.

“Emergency vehicle driver” or *“driver”* means a currently licensed driver rostered with the service program or other emergency response personnel with emergency vehicle driving training.

“EMS clinical guidelines” or *“minimum EMS clinical guidelines”* means a minimum clinical standard approved by the department upon which a service program’s medical director will base service program protocols.

“Endorsement” means an approval granted by the department authorizing a paramedic level service program to provide critical care transport (CCT).

“FAA” means Federal Aviation Administration.

“Fixed-wing ambulance” means any privately or publicly owned fixed-wing aircraft specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated who are in need of out-of-hospital emergency medical care or whose condition requires treatment or continuous observation while being transported.

“First response vehicle” means any privately or publicly owned vehicle that is not an ambulance and that is used solely for the transportation of personnel and equipment to and from the scene of an emergency.

“Full authorization” means a service program authorization under which a service is authorized to provide and routinely provides a specific level of emergency medical care for initial 911 or emergency calls 24 hours per day, seven days per week.

“Hospital” means any hospital licensed under the provisions of Iowa Code chapter 135B.

“Medical direction” means direction, advice, or orders provided by a medical director, supervising physician, PA, or ARNP to emergency medical care personnel.

“Medical director” means a physician designated by the service program and responsible for providing medical direction and overall supervision of the medical aspects of the service program.

“Nontransport service” means any privately or publicly owned service program that does not provide patient transportation and provides emergency medical care at the scene of an emergency.

“Paramedic” or *“EMT-P”* means an emergency medical technician-paramedic.

“Paramedic level service” or *“PM level service”* means a service program that provides emergency medical care that does not exceed the scope of practice of a certified paramedic provider as outlined in 641—subrule 131.4(2).

“Paramedic specialist” or *“PS”* means an individual who has successfully completed the current U.S. Department of Transportation’s EMT-Paramedic curriculum or equivalent, has passed the department’s approved written and practical examinations, and is currently certified by the department as a paramedic specialist.

“Patient” means any individual who is sick, injured, or otherwise incapacitated.

“Patient care report” or *“PCR”* means a report that documents the assessment and management of the patient by the emergency care provider.

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician assistant” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Primary response ambulance” means any ambulance utilized by a service program and dispatched as the initial ambulance response to a 911 or emergency call.

“Protocols” means written directions and orders approved by a service program’s medical director utilizing the EMS clinical guidelines.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Rotorcraft ambulance” means any privately or publicly owned rotorcraft specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated who are in need of out-of-hospital emergency medical care or whose condition requires treatment or continuous observation while being transported.

“Service director” means an individual designated by the service program who is responsible for the operation and administration of a service program.

“Service program” or *“service”* means any ground or air medical transport service or nontransport service, inclusive of associated satellites, that has received full or conditional authorization from the department.

“Service program affiliate” or *“affiliate”* means an independently owned service program affiliated with one or more service programs or a separate management entity.

“Service program affiliate agreement” or *“affiliate agreement”* means a written agreement executed between one or more service programs or one or more management entities and filed with the department that clearly defines the responsibilities of each service program to ensure compliance with these rules.

“Service program base of operation” means the physical location from which a service program responds and at which the service program houses emergency medical care personnel and equipment.

“Service program ownership” means the legal owner of the service program responsible for providing emergency medical care and compliance with Iowa Code chapter 147A and these rules.

“*Service program satellite*” or “*satellite*” means one or more additional service program locations owned by the same service program.

“*Student*” means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portions.

“*Tiered response*” means a rendezvous between service programs to allow the transfer, continuation, or enhancement of patient care.

“*Transport agreement*” means a written agreement executed between two or more service programs and filed with the department that ensures response and transportation for initial 911 or emergency calls. A transport agreement may be a component of an affiliate agreement.

“*Transport service*” means any privately or publicly owned service program that utilizes ambulances in order to provide patient transportation.

641—132.2(147A) Service program—authorization and renewal procedures and inspections.

132.2(1) *Requirements for initial service program authorization.*

a. An entity that desires to provide emergency medical care services in the out-of-hospital setting in this state shall apply to the department for service program full authorization.

b. Information for initial authorization can be found on the department’s website or upon request.

c. Transport service—full authorization. An entity seeking authorization as a transport service program shall apply for full authorization at a minimum of the EMT level or the level of care that will be provided by the service program or through a transport agreement for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

d. Transport service—conditional service level authorization. An entity seeking authorization as a transport service that is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) AEMT.
- (2) Paramedic.

e. Nontransport service—full authorization. An entity seeking authorization as a nontransport service program shall apply for full authorization at a minimum of the EMR level or at the level of care that will be provided for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMR.
- (2) EMT.
- (3) AEMT.
- (4) Paramedic.

The nontransport service program shall have an executed written transport agreement ensuring simultaneous dispatch with an authorized transport service program for all 911 or emergency calls.

f. Nontransport service—conditional service level authorization. An entity seeking authorization as a nontransport service program that has an executed written transport agreement ensuring simultaneous dispatch with an authorized transport service program for all 911 or emergency calls and is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

g. Conditional service level authorization requirements.

(1) A service program that has been granted conditional service level authorization shall only advertise or otherwise hold itself out to the public as an authorized service program at the level of full authorization.

(2) A service program authorized to operate at a conditional service level shall operate at such level only when an emergency medical care provider certified at the advanced certification level is listed on the service roster, physically present and directly responsible for patient care.

h. Initial service program authorization is valid for a period of one year from its effective date unless otherwise specified on the certificate of authorization or unless sooner suspended or revoked or surrendered.

i. An applicant shall provide evidence of liability insurance coverage for the service program and emergency medical care provider staff. Any change in insurance status must be reported to the department no later than 30 days from the change.

j. An applicant seeking endorsement must submit a department-approved application.

132.2(2) *Requirements for renewal of service program authorization.*

a. A service program seeking renewal of current authorization shall submit all required documentation to the department at least 90 days prior to the current authorization expiration date.

b. Transport service—full authorization. An entity seeking renewal authorization as a transport service program shall apply for full authorization at a minimum of the EMT level or the level of care that will be provided by the service program or through a transport agreement for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

c. Transport service—conditional service level authorization. An entity seeking renewal authorization as a transport service that is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) AEMT.
- (2) Paramedic.

d. Nontransport service—full authorization. An entity seeking renewal authorization as a nontransport service program shall apply for full authorization at a minimum of the EMR level or at the level of care that will be provided for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMR.
- (2) EMT.
- (3) AEMT.
- (4) Paramedic.

e. Nontransport service—conditional service level authorization. An entity seeking renewal authorization as a nontransport service program that is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

f. Air medical requirements.

(1) Staff fixed-wing ambulances, at a minimum on each flight request, with the following staff while a patient is being transported:

1. One health care clinician who is certified or licensed in the state from which the aircraft launches and is certified as an EMS-Basic or higher level; and

2. One FAA-certified commercial pilot who is appropriately rated in the aircraft being used for the transport.

(2) Staff rotor craft ambulances, at a minimum on each flight request, with the following staff while a patient is being transported:

1. Two health care clinicians who are certified or licensed in the state from which the aircraft launches, one of whom must at a minimum be certified as a paramedic specialist; and
2. One FAA-certified commercial pilot who is appropriately rated in the aircraft being used for the transport.

(3) Medical crew members trained in the following areas:

1. Patient care limitations in flight.
2. Altitude physiology.
3. Appropriate utilization of air medical services.
4. Air medical communication systems.
5. Aircraft operations and safety.
6. Emergency safety and survival.
7. Prehospital scene response and safety.
8. Crew resource management.
9. Program flight risk assessment procedures.
- g. Conditional service level authorization requirements.

(1) A service program that has been granted conditional service level authorization shall only advertise or otherwise hold itself out to the public as an authorized service program at the level of full authorization.

(2) A service program authorized to operate at a conditional service level shall operate at such level only when an emergency medical care provider certified at the advanced certification level is listed on the service roster, physically present and directly responsible for patient care.

h. A service program that has submitted to the department fewer than 100 data reports per year for each of the previous two consecutive calendar years shall only be eligible for renewal of current authorization as an affiliate. The department will provide technical assistance in developing affiliations.

i. A service program shall be fully operational upon the effective date specified on the certificate of authorization and shall ensure compliance with Iowa Code chapter 147A and these rules.

j. A service program renewal authorization is valid for a period not to exceed three years from its effective date unless otherwise specified on the certificate of authorization or unless sooner revoked or suspended or surrendered.

132.2(3) *Reinstatement of service program authorization.*

a. A service program whose full authorization or conditional service level authorization has been revoked or suspended or surrendered may apply to the department for reinstatement in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the authorization is permanently revoked.

b. If the authorization was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender.

132.2(4) *Out-of-state service programs.*

a. An emergency medical service program authorized and based in another state shall provide the department with verification of current state authorization upon request and may provide emergency medical care to patients in Iowa.

b. A service program authorized and based in another state shall meet all requirements of Iowa Code chapter 147A and these rules and must be authorized by the department to respond to 911 requests in Iowa to transport patients in Iowa to locations within Iowa.

132.2(5) *Service program inspections.*

a. The department, at a minimum, will complete an inspection of each base of operations, all associated satellites, and all affiliate locations prior to initial authorization or renewal of current full

authorization or conditional service level to ensure compliance with Iowa Code chapter 147A and these rules.

b. The department without prior notification may make additional inspections at times, at places and under such circumstances as it deems necessary to ensure compliance with Iowa Code chapter 147A and these rules.

c. Service program inspection forms are available on the department's website.

d. A service program shall correct deficiencies identified during a service program inspection within the time period specified by the department on the inspection form. Failure to correct identified deficiencies within the specified time period may result in disciplinary action.

e. The department may request additional information from or may inspect the records of any service program or associated satellite or associated affiliate that is currently authorized or that is seeking authorization to ensure continued compliance or to verify the validity of any information presented on the application for initial service program authorization or renewal of current authorization.

f. The department may inspect the patient care records of a service program to verify compliance with Iowa Code chapter 147A and these rules.

g. No person shall interfere with the inspection activities of the department or its agents pursuant to Iowa Code section 135.36.

h. Interference with or failure to allow an inspection by the department or its agents may be cause for disciplinary action.

641—132.3(147A) Service program operations.

132.3(1) *Ownership.*

a. Each service program will have a unique authorization number assigned by the department.

b. A service program with satellites will have a single authorization number assigned by the department for all locations.

c. A service program owner shall ensure compliance with Iowa Code chapter 147A and these rules.

d. A service program shall report any change in ownership to the department at least seven days prior to the change.

e. A service program changing ownership shall apply to the department at least seven days prior to the change in ownership for initial authorization in accordance with 132.2(1).

132.3(2) *Medical director.*

a. Each service program shall have a designated medical director at all times.

b. A medical director shall:

(1) Be accessible for medical direction 24 hours per day, seven days per week or ensure accessibility to alternate medical direction.

(2) Ensure that all duties and responsibilities of the medical director are not relinquished before a new or temporary replacement is functioning in that capacity.

(3) Complete a department-sponsored medical director training within one year of assuming duties as a medical director and at a minimum once every three years thereafter.

(4) Develop, approve, and update service program guidelines that meet or exceed the minimum EMS clinical guidelines approved by the department.

(5) Ensure that the emergency medical care providers rostered with the service program are credentialed in the emergency medical skills to be provided and the duties of the emergency medical care provider do not exceed the provider's scope of practice as referenced in 641—subrule 131.4(2) and the service program's EMS service level of authorization.

(6) Be available for individual evaluation and consultation with service program personnel.

(7) Have authority to restrict a service program's authorized functional EMS service level.

(8) Have the authority to permanently or temporarily restrict a service program member to function within a lower level scope of practice or prohibit a service program member from providing patient care.

(9) Approve the service program's CQI program.

(10) Perform or complete, or appoint a designee to perform or complete, the medical audits in the service program's established CQI policy.

(11) Randomly audit (on at least a quarterly basis) documentation of calls where emergency medical care was provided.

(12) Randomly review audits performed by the qualified appointee.

c. A medical director may:

(1) Make additions to the department-approved EMS clinical guidelines when developing service guidelines, provided the additions are within the service program's level of authorization, the EMS provider's scope of practice, and acceptable medical practice.

(2) Request that service program providers provide additional emergency medical care skills on a limited pilot project basis. The pilot project applications are available from the department upon request.

(3) Approve the physician, PA and RN exception form identifying the level of EMS provider equivalency not to exceed the service program's EMS service level authorization for each physician, PA and RN who will be providing emergency medical care as part of the service program.

d. A medical director who receives no compensation for the performance of the director's volunteer duties under this chapter is considered a state volunteer as provided in Iowa Code section 669.24 while performing volunteer duties as an emergency medical services medical director. Compensation does not include payments for reimbursement of expenses.

e. A medical director, supervising physician, PA, or ARNP who gives orders to an emergency medical care provider is not subject to criminal liability by reason of having issued the orders and is not liable for civil damages for acts or omissions relating to the issuance of the orders unless the acts or omissions constitute recklessness.

f. Nothing in these rules requires or obligates a medical director, supervising physician, PA, or ARNP to approve requests for orders received from an emergency medical care provider.

g. A service program medical director who fails to comply with Iowa Code chapter 147A or these rules may be referred to the Iowa board of medicine.

132.3(3) Service director.

a. Each service program shall have a designated service director at all times.

b. A service director shall:

(1) Be accessible 24 hours per day, seven days per week or ensure accessibility to a service director designee.

(2) Be responsible for providing direction and overall supervision of the administrative and operational aspects of the service program.

(3) Ensure that all duties and responsibilities of the service director are not relinquished before a new or temporary replacement is functioning in that capacity.

(4) Complete a department-sponsored training within one year of assuming duties as a service director and at a minimum once every three years thereafter.

(5) Ensure the service program is in compliance with service program policy, Iowa Code chapter 147A and these rules.

(6) Ensure that duties of the service program's emergency medical care providers do not exceed the providers' scope of practice as referenced in 641—subrule 131.4(2) or the service program's EMS service level of authorization.

132.3(4) Service program requirements.

a. A service program shall:

(1) Not advertise or otherwise imply or hold itself out to the public as a service program unless currently authorized by the department.

- (2) Only advertise at or otherwise hold itself out as having the level of full authorization.
- (3) Select a new or temporary medical director if the current medical director cannot or no longer wishes to serve in that capacity. Selection shall be made before the current medical director relinquishes the duties and responsibilities of that position.
- (4) Notify the department in writing within seven days prior to any change in medical director or any reduction or discontinuance of operations.
- (5) Select a new or temporary service director if the current service director cannot or no longer wishes to serve in that capacity. Selection shall be made before the current service director relinquishes the duties and responsibilities of that position.
- (6) Notify the department in writing within seven days prior to any change in service director or any reduction or discontinuance of operations.
- (7) Notify the department within seven days prior to any change in location of a service program base of operations, administrative office, satellite, or affiliate.
- (8) Notify the department within seven days when entering into agreements with one or more service programs or a management entity to form multiservice systems for shared service program management, administration, data submission, or other services to ensure compliance with these rules.
- (9) Report the termination or resignation in lieu of termination of an emergency medical care provider due to negligence, professional incompetency, unethical conduct, substance use, or violation of any of these rules to the department in writing within seven days.
- (10) Report theft of drugs to the department in writing within 48 hours following the occurrence of the incident.
- (11) Develop a notification process for service members in the event of a motor vehicle collision involving a first response vehicle, ambulance, rescue vehicle or personal vehicle when used by a service program member responding as a member of the service program.
- (12) Notify the department in writing within 48 hours of a motor vehicle collision resulting in personal injury or death.
- (13) Ensure a response to an initial 911 or emergency call request to the service program, 24 hours per day, seven days per week.
- (14) Utilize guidelines developed and approved by the service program medical director that meet or exceed the minimum EMS clinical guidelines approved by the department.
- (15) Ensure alterations to the minimum EMS clinical guidelines by the service program's medical director are approved by and filed with the department.
- (16) Maintain a communication system at a minimum between medical direction, receiving facility, and other emergency responders.
- (17) Maintain a current personnel roster utilizing a department-approved registry system. Ensure all rostered personnel are currently certified as active EMS providers in the state of Iowa.
- (18) Maintain files with the medical director and department-approved physician, PA and RN exception forms for appropriate personnel. PA and RN forms are available on the department's website.
- (19) Ensure all service program members who operate motorized emergency response vehicles, ambulances, and rescue vehicles when used by a service member responding as a member of the service have a valid driver's license and attend driver training prior to driving an emergency vehicle.
- (20) Develop, maintain and follow a written driver training policy that includes a review of Iowa laws regarding emergency vehicle operations (Iowa Code section 321.231), frequency of service required driver training, a review of service program policies and criteria for response with lights or sirens or both, speed limits, procedure for approaching intersections, and use of the service program communications equipment.
- (21) Ensure the emergency medical care provider with the highest level of certification attends the patient unless otherwise indicated by patient assessment and approved by the service program's guidelines.

b. A transport service program shall:

(1) Provide as a minimum, on initial 911 or emergency calls, the following staff on each primary response ambulance:

1. One currently certified emergency medical care provider certified at the service program full level of authorization.

2. One driver.

(2) Provide as a minimum on each subsequent call or nonemergency call, when responding, the following staff:

1. One currently certified EMT.

2. One driver.

(3) Establish a transport decision policy that requires a complete assessment of a patient in order to determine transport needs. The service transport decision policy shall include:

1. The Out-of-Hospital Trauma and Triage Destination Decision Guideline as described in 641—Chapter 135.

2. Time critical condition considerations for transport to facilities that specialize in conditions such as cardiac conditions or stroke.

3. A process for a service program provider to determine transportation to a hospital, medical clinic, extended care facility, or other facilities where health care is routinely provided.

4. A process for patient refusal or nontransport if emergency transport is not warranted. The service program provider will obtain a signed transport/treatment refusal document or liability release if transport is not required.

5. A process by which a service program provider may make arrangements for alternate transport if emergency transport is not needed and remain with the patient until alternate transport arrives unless the provider is called to respond to another emergency.

c. Nontransport service programs.

(1) Nontransporting service programs, when responding to 911 or emergency calls, shall provide as a minimum one currently certified emergency medical care provider certified at the service program full level of authorization.

(2) Nontransport service programs shall have an executed written transport agreement ensuring simultaneous dispatch with an authorized transport service program for all 911 or emergency calls.

(3) Nontransport service programs may transport patients in an ambulance only in an emergency situation when lack of transporting resources would cause an unnecessary delay in patient care.

132.3(5) Data reporting.

a. A service program shall report data electronically to the department.

b. A service program shall submit data in a format approved by the department.

c. A service program shall submit reportable data to the department no later than the last day of the month following the month services were provided.

d. The data collected by the EMS data registry and furnished to the department pursuant to this rule are confidential records of the condition, diagnosis, care, or treatment of patients or former patients, including outpatients, pursuant to Iowa Code section 22.7. The compilations prepared for release or dissemination from the data collected are not confidential under Iowa Code section 22.7(2). However, information that individually identifies patients shall not be disclosed, and state and federal law regarding patient confidentiality shall apply.

e. The department may approve requests for reportable patient data for special studies and analysis provided:

(1) The request has been reviewed and approved by the department with respect to the scientific merit and confidentiality safeguards.

(2) The department has given administrative approval for the proposal.

(3) The confidentiality of patients is protected pursuant to Iowa Code section 22.7 and chapter 147A.

(4) The department may require those requesting the data to pay any or all of the reasonable costs associated with furnishing the reportable data.

f. For the purpose of ensuring the completeness and quality of reportable data, the department or authorized representative may examine all or part of the data record as necessary to verify or clarify all reportable data submitted by a service program.

g. To the extent possible, activities under this subrule shall be coordinated with other health data collection methods.

h. A service program will develop, maintain and follow a written data submission policy.

132.3(6) *Patient care reporting.*

a. Each service program, satellite, and affiliate shall complete and maintain a patient care report documenting the care provided to each patient.

b. The patient care report is a confidential document and is exempt from disclosure pursuant to Iowa Code section 22.7(2) and shall not be accessible to the general public. Information contained in these reports, however, may be utilized by any of the indicated distribution recipients and may appear in any document or public health record in a manner that prevents the identification of any patient or person named in these reports.

c. To facilitate the continuum of care, transport service programs shall provide at a minimum, upon delivery of a patient to a receiving facility, a verbal patient care report that contains details of the assessment and care provided.

d. Transport service programs shall provide a final patient care report within 24 hours to the receiving facility. Transport services and receiving facilities must work together to initiate reasonable and realistic mechanisms (including but not limited to paper, secure email, secure links, secure electronic system retrieval, and access to printers at the receiving facility) to ensure the delivery of the patient care report.

e. A service program will develop, maintain, and follow a written patient care report policy.

132.3(7) *Continuous quality improvement (CQI).*

a. A service program shall develop, maintain, and follow a CQI program that follows a written CQI policy.

b. The CQI program shall include medical audits that review patient care provided.

c. The CQI program shall be utilized to identify deficiencies or potential deficiencies regarding medical knowledge or skill or procedure performance.

d. The CQI program shall review at a minimum 911 response and scene times.

e. The CQI program shall develop a written plan that monitors, identifies and documents at a minimum continuing education, credentialing of skills and procedures, and personnel performance for the service program's emergency medical care providers, drivers, physicians, PA and RN exceptions.

f. The CQI program shall establish measurable outcomes that reflect the goals and standards of the service program.

g. The CQI program shall ensure completion of loop closure/resolution of identified areas of concern.

132.3(8) *Medications in service programs.*

a. A service program shall have written pharmacy agreements in accordance with the Iowa board of pharmacy's 657—Chapter 11.

b. A service program shall maintain all medications in accordance with the rules of the Iowa board of pharmacy's 657—Chapters 10 and 11.

c. A service program shall develop, maintain, and follow a written pharmacy policy.

132.3(9) *Vehicle standards, supplies, equipment and maintenance.*

a. All service programs, regardless of their designation as governmentally owned, not-for-profit, or privately operated, shall annually systematically inspect, repair, and maintain, or cause to be systematically inspected, repaired, and maintained, all ambulances operated by the service program.

b. A service program shall utilize a vehicle inspection report approved by the department to record the results of an annual ambulance safety inspection. Annual safety inspection forms that comply with the requirements of 49 CFR 396 as amended to August 1, 2024, shall be approved by the

department. A sample annual vehicle inspection form that complies with the reporting requirements of 49 CFR 396 as amended to August 1, 2024, can be found on the department's website.

c. A service program shall ensure individuals performing annual safety inspections are qualified and capable of performing an inspection by reason of experience, training, or both.

d. A service program shall not use an ambulance that fails to meet or maintain the requirements of this subrule to transport patients.

e. A service program shall house primary response ambulances in a garage or other enclosed facility that is maintained in a clean, safe condition, free of debris or other hazards; is temperature controlled; and has an unobstructed exit to the street.

f. A service program shall secure all equipment stored in the ambulance patient compartment so the patient and service program personnel are not injured by moving equipment.

g. New ambulances manufactured and placed into service shall meet at a minimum either the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances or the National Fire Protection Association (NFPA) Standard for Automotive Ambulances (NFPA 1917).

h. A service program shall maintain first response and rescue vehicles in safe operating condition and provide regular maintenance. Vehicles shall have the exterior clean and the interior clean and disinfected.

i. A service program shall ensure medical and patient care supplies are monitored for expiration dates, cleaned, laundered or disinfected. All medical supplies shall be stored in clean environments.

j. A service program shall ensure personal protection equipment and supplies are available to ensure emergency medical care responder safety during every response.

k. A service program shall ensure supplies to properly dispose of biomedical hazardous waste are available in all response vehicles, and all waste shall be disposed of according to accepted biomedical waste practices.

l. A service program shall ensure medical equipment is maintained per manufacturer requirements for safe emergency medical care provider and patient use.

m. A service program will develop, maintain, and follow vehicle standards, supplies, and equipment maintenance policies.

641—132.4(147A) Waivers. If during a period of authorization, a service program is unable to maintain compliance with Iowa Code chapter 147A and these rules, the department may grant a waiver.

132.4(1) The department may grant waivers of these rules to a currently authorized service program.

132.4(2) Requests for waivers shall apply only to the service program requesting the waiver and shall apply only to those requirements and standards for which the department is responsible.

132.4(3) A service program shall apply for a waiver in accordance with 441—Chapter 6.

641—132.5(147A) Complaints and investigations—denial, citation and warning, probation, suspension or revocation of service program authorization or renewal.

132.5(1) All complaints regarding the operation of authorized emergency medical care service programs, or those purporting to be or operating as the same, shall be reported to the department.

132.5(2) Complaints and the investigative process will be treated as confidential in accordance with Iowa Code section 22.7 and chapter 272C. An emergency medical care provider who has knowledge of an emergency medical care provider, service program or training program that has violated Iowa Code chapter 147A or these rules shall report such information to the department within 30 days following knowledge of the violation.

132.5(3) Service program authorization may be denied, issued a civil penalty not to exceed \$1,000, issued a citation and warning, placed on probation, suspended, revoked, or otherwise

disciplined by the department in accordance with Iowa Code section 147A.5(3) for any of the following reasons:

- a.* Knowingly allowing the falsifying of a patient care report (PCR).
- b.* Failure to submit required reports and documents.
- c.* Delegating professional responsibility to a person when the service program knows that the person is not qualified by training, education, experience or certification to perform the required duties.
- d.* Practicing, condoning, or facilitating discrimination against a patient, student or employee based on race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability diagnosis, or social or economic status.
- e.* Knowingly allowing sexual harassment of a patient, student or employee. Sexual harassment includes sexual advances, sexual solicitations, requests for sexual favors, and other verbal or physical conduct of a sexual nature.
- f.* Failure or repeated failure of the applicant or alleged violator to meet the requirements or standards established pursuant to Iowa Code chapter 147A or the rules adopted pursuant to that chapter.
- g.* Obtaining or attempting to obtain or renew or retain service program authorization by fraudulent means or misrepresentation or by submitting false information.
- h.* Engaging in conduct detrimental to the well-being or safety of the patients receiving or who may be receiving emergency medical care.
- i.* Failure to correct a deficiency within the time frame required by the department.
- j.* Engaging in any conduct that subverts or attempts to subvert a department investigation.
- k.* Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.
- l.* Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.
- m.* Knowingly aiding, assisting or advising a person to unlawfully practice EMS.
- n.* Acceptance of any fee by fraud or misrepresentation.
- o.* Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.
- p.* Violating privacy and confidentiality. A service program shall not disclose or be compelled to disclose patient information unless disclosure is required or authorized by law.
- q.* Practicing emergency medical services or using a designation of certification or otherwise holding itself out as practicing emergency medical services at a certain level of authorization when the service program is not authorized at such level.
- r.* Failure to respond within 30 days of receipt, unless otherwise specified, of communication from the department which was sent by registered or certified mail.

132.5(4) The department will notify the applicant of the granting or denial of authorization or renewal, or will notify the alleged violator of action to issue a citation and warning, place on probation or suspend or revoke authorization or renewal pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a denial, citation and warning, probation, suspension or revocation will be served by restricted certified mail, return receipt requested, or by personal service.

132.5(5) Any requests for appeal concerning the denial, citation and warning, probation, suspension or revocation of service program authorization or renewal shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. After the hearing, or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the denial, citation and warning,

probation, suspension or revocation. If no request for appeal is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation shall become the department's final agency action.

132.5(6) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections, appeals, and licensing pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information that may be provided by the aggrieved party shall also be provided to the department of inspections, appeals, and licensing.

132.5(7) The hearing shall be conducted according to the procedural rules of the department of inspections, appeals, and licensing, found in 481—Chapter 10.

132.5(8) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in 132.5(9).

132.5(9) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in accordance with 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 147A and 2024 Iowa Acts, House File 2507.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 133
“White Flashing Light Authorization”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 321.423

State or federal law(s) implemented by the rulemaking: Iowa Code section 321.423

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter establishes issuance standards for white flashing light use, including allowing local emergency medical service providers to issue certificates of authorization, and establishes certificate of authorization revocation procedures.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
The public will benefit because the use of flashing white lights will be closely regulated to help prevent misuse.
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:
There are an unknown number of white light authorizations in the state of Iowa. Authorizations are verified during the inspection process. Approximately 250 to 300 service program authorizations are completed each year.
 - Qualitative description of impact:
Iowa’s roads are safer because the potential for misuse of flashing white lights is reduced.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:

Personnel and other administrative costs will be borne by the Department.

- Anticipated effect on state revenues:

There will be no impact on state revenues.

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

There are no costs associated with the rulemaking. Further, it is required by law.

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

There are no less costly methods or less intrusive methods.

6. Alternative methods considered by the agency:

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

None were seriously considered.

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

Rulemaking is both appropriate and required by law.

Small Business Impact

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

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

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

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 133 and adopt the following new chapter in lieu thereof:

CHAPTER 133 WHITE FLASHING LIGHT AUTHORIZATION

641—133.1(321) Definitions. For the purpose of these rules, the following definitions shall apply:

“Ambulance” means the same as defined in rule 641—132.1(147A).

“Authorization certificate” means a permit issued to an emergency medical care provider that authorizes the use of a white flashing light.

“Authorized vehicles” means any vehicles owned by members of the service program that are authorized by the department to use flashing white lights.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“First response vehicle” means the same as defined in rule 641—132.1(147A).

“Medical director” means the same as defined in rule 641—132.1(147A).

“Member” means any individual utilized by an ambulance or nontransport service to provide emergency medical care.

“Nontransport service” means the same as defined in rule 641—132.1(147A).

“Rescue vehicle” means the same as defined in Iowa Code section 321.1.

“Service director” means the same as defined in rule 641—132.1(147A).

“Service program” or *“service”* means the same as defined in Iowa Code section 147A.1.

“White light” means a white or clear rotating, flashing, or strobe lighting device utilized for identification purposes only. Any such lighting device shall not display a constant white or clear light to the rear of the vehicle.

641—133.2(321) Purpose.

133.2(1) Flashing white lights may be used on emergency vehicles or other authorized vehicles utilized by emergency medical care providers and service programs for identification purposes only.

133.2(2) Flashing white lights shall be used only on an authorized vehicle and shall not be used except in any of the following circumstances:

- a. When responding to an emergency in the line of duty requiring the services of the member.
- b. When at the scene of an emergency.
- c. When transporting a patient during a disaster situation.

133.2(3) Owners and operators of authorized vehicles are responsible for ensuring that the lighting devices are utilized in a safe manner. This includes but is not limited to ensuring that lighting devices do not:

- a. Obstruct the view of the vehicle operator.
- b. Overburden the electrical system of the vehicle.
- c. Interfere with the vision of the vehicle operator, passengers, or drivers of other vehicles.

133.2(4) Operators of authorized vehicles shall ensure that the authorization certificate is carried in the vehicle.

641—133.3(321) Application.

133.3(1) Authorization certificates will be issued by the service director for service vehicles and vehicles owned by emergency medical care providers who are members in good standing with the service. Authorization certificates are available from the department upon request. Vehicle authorization is limited to:

- a. Vehicles owned or exclusively operated by the ambulance or nontransport service.
- b. Vehicles owned or operated by emergency medical care provider members of the ambulance or nontransport service.
- c. Vehicles owned or operated by the service program’s medical director.
- d. One authorization certificate per vehicle.

133.3(2) Nothing in these rules prevents the use of white flashing lights on vehicles that are authorized to use red or blue flashing lights.

133.3(3) The service director shall provide, upon request of the department or its agents, issued authorization certificates.

133.3(4) The authorization expires five years from the date issued unless sooner suspended or revoked.

133.3(5) The department may issue authorization certificates for vehicles used by employees of the department when responding to emergencies or disasters.

641—133.4(321) Approval, denial, probation, suspension and revocation of authorization.

133.4(1) The service director or the department may approve or deny an application and the department may place on probation, suspend or revoke an authorization certificate if the service director or the department finds reason to believe that the applicant or certificate holder:

- a. Has failed to meet all applicable requirements of these rules.
- b. Has been convicted of a moving violation while using flashing white lights.
- c. Has utilized a white flashing light without obtaining an authorization certificate.

- d.* Does not have a valid driver's license.
- e.* Does not have a current vehicle registration.

133.4(2) The authorization certificate shall be surrendered upon the request of the department or its agents.

133.4(3) An emergency medical care provider or service director who has knowledge of any emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall, within 30 days, report that information to the department.

133.4(4) A denial, probation, suspension or revocation ordered by the department shall be effected, and may be appealed according to the provisions set forth in 441—Chapter 7.

These rules are intended to implement Iowa Code section 321.423.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 134
“Trauma Care Facility Categorization and Verification”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.27

State or federal law(s) implemented by the rulemaking: Iowa Code section 147A.23

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking helps ensure all Iowa hospitals are verified to be equipped with the appropriate resources to provide trauma services and optimal care for injured patients. The chapter adopts by reference published national guidelines with required criteria/standards for hospitals to be verified trauma centers. The chapter also outlines the verification process, timeline, and disciplinary processes.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans in need of trauma care services will benefit.
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:
The state trauma program maintains verification for all hospitals in the state of Iowa. There are currently 2 Level I adult trauma care facilities, 1 Level I pediatric trauma care facility, 2 Level II adult trauma care facilities, 1 Level II pediatric trauma care facility, 13 Level III trauma care facilities, and 100 Level IV trauma care facilities.
 - Qualitative description of impact:

Iowa has had a proud tradition of a robust trauma system since the late 1990s. Iowa is considered a leader in trauma system development across the nation. It is a strength for Iowa that every hospital, no matter where it is located, is prepared to care for injured patients. Other states model their laws and rules on Iowa's.

3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
Personnel and other administrative costs are borne by the agency.
- Anticipated effect on state revenues:
No impact on state revenues is anticipated.

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

Without this chapter, Iowa would not have an inclusive trauma system. Hospitals would not have consistent guidance and accountability to maintain the appropriate resources to provide optimal care to injured patients. The statewide trauma system would fall below national standards, impacting fatally and non-fatally injured Iowans.

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

This rulemaking is appropriate and required by law.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
No alternative methods were considered.
- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 134 and adopt the following **new** chapter in lieu thereof:

CHAPTER 134

TRAUMA CARE FACILITY CATEGORIZATION AND VERIFICATION

641—134.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“ACS-COT” means the American College of Surgeons Committee on Trauma.

“Categorization” means the same as defined in Iowa Code section 147A.21.

“Certificate of verification” means a document awarded by the department that identifies a hospital or emergency care facility’s level and term of verification as a trauma care facility.

“Criteria deficiency” or *“deficiency”* means a failure to meet criteria requirements as outlined in subrule 134.2(3).

“Emergency care facility” means the same as defined in Iowa Code section 147A.21.

“Emergency medical care provider” means emergency medical care provider as defined in Iowa Code section 147A.1.

“Final report” means the verification report issued by the department following a verification review conducted by trauma survey team members and department staff.

“Governing body” means a group of individuals responsible for the governance of a hospital, including but not limited to a board of directors or board of trustees.

“Hospital” means any hospital licensed under Iowa Code chapter 135B.

“On-site verification survey” means an on-site survey conducted by the department or survey team members to assess a hospital or emergency care facility’s ability to meet the level of categorization requested.

“Persistently occurring deficiencies” means deficiencies identified in two sequential verification reviews.

“Trauma” means the same as defined in Iowa Code section 147A.21.

“Trauma care facility” means the same as defined in Iowa Code section 147A.21.

“Trauma survey team” means a group of health care providers contracted by the department to assist in verifying trauma care facilities’ compliance with trauma criteria adopted in subrule 134.2(3).

“Type I criteria” or *“type I criteria deficiency”* indicates criteria requirements that may significantly impact a trauma care facility’s ability to provide optimal care for trauma patients.

“Type II criteria” or *“type III criteria deficiency”* indicates criteria that are required but have a less critical impact on the trauma care facility’s ability to provide optimal care for trauma patients than type I criteria.

“Verification” means the same as defined in Iowa Code section 147A.21.

641—134.2(147A) Trauma care facility categorization and verification. Categorization and verification of trauma care facilities will be made by the department in accordance with Iowa Code section 147A.23.

134.2(1) Categorization applications shall be submitted by all hospitals. New hospitals and emergency care facilities shall submit a categorization application no later than 90 days after licensing by the department of inspections, appeals, and licensing.

134.2(2) Categorization levels for trauma care facilities shall be identified as:

- a. Level I.
- b. Level II.
- c. Level III.
- d. Level IV.

134.2(3) Adoption by reference. Criteria specific to level I, II, and III trauma care facilities identified in the “Resources for Optimal Care of the Injured Patient” 2022 Standards published by the American College of Surgeons (ACS) is incorporated and adopted by reference for level I, II, and III hospital and emergency care facility categorization criteria. Criteria specific to level IV trauma care facilities identified in the “Resources for Optimal Care of the Injured Patient 2014” published by the ACS is incorporated and adopted by reference for level IV hospital and emergency care categorization criteria. For any differences that may occur between the adopted references and these administrative rules, the administrative rules shall prevail.

134.2(4) Categorization shall not be construed to imply any guarantee on the part of the department as to the level of trauma care services available at a trauma care facility.

134.2(5) A verified trauma care facility may apply to the department for a change in level of categorization through submission of a self-assessment categorization application.

134.2(6) Verification of a trauma care facility will be determined by the department upon successful completion of the categorization application and completion of a verification survey. All categorized hospitals and emergency care facilities shall be verified.

a. Level I and II trauma care facilities shall be verified by the ACS-COT.

b. Trauma care facilities verified by the ACS-COT will be accepted by the department as equivalent for categorization and verification as a trauma care facility in Iowa provided that all policy, reporting, and administrative rules have been met. The department may issue a certification of verification provided that the trauma care facility has been verified by the ACS-COT. The facility shall provide the department documentation including but not limited to a current copy of the ACS-COT verification.

c. A level I or II trauma care facility that fails to attain ACS-COT verification shall submit an application to the department to be verified as a level III or IV trauma care facility to ensure compliance with Iowa Code section 147A.23(2)“a.”

d. Level III and IV trauma care facilities will be verified by the department in consultation with the trauma survey team.

134.2(7) The department will conduct a verification survey for categorized hospitals or emergency care facilities.

a. Type I and II criteria deficiencies identified during the verification process shall be resolved in accordance with the trauma care facility’s final report. Failure to rectify deficiencies in accordance with the trauma care facility’s final report may result in disciplinary action.

b. The department may conduct electronic review or on-site verification that criteria deficiencies have been resolved as outlined in final reports or disciplinary actions.

c. The department will notify the applicant in writing as to the approval or denial of verification as a trauma care facility within 90 days after the completion of a verification survey.

d. Verification cannot be construed to imply any guarantee on the part of the department as to the level of trauma care services available at a hospital or emergency care facility.

e. Trauma care facility verification is valid for a period of three years from the effective date unless otherwise specified on the certificate of verification or unless sooner suspended or revoked.

f. Trauma care facilities shall be fully operational at their verified level upon the effective date specified on the certificate of verification.

g. Trauma care facilities that are unable to maintain their categorization or verification, or both, must notify the department within 48 hours.

h. The director, pursuant to 441—Chapter 7, may grant a waiver from the requirements of rules adopted under this chapter for any trauma care facility.

i. Proceedings, records, and reports developed pursuant to this chapter constitute peer review records under Iowa Code section 147.135 and are not subject to discovery by subpoena or admissible as evidence. All information and documents received from a hospital, emergency care facility, or trauma care facility under Iowa Code chapter 147A are confidential pursuant to Iowa Code section 272C.6(4).

641—134.3(147A) Complaints, investigations and appeals.

134.3(1) The department may deny verification as a trauma care facility or may give a citation and warning, place on probation, suspend, or revoke existing verification if the department finds reason to believe that the facility has not been operating or will not be operated in compliance with Iowa Code section 147A.23 and these administrative rules or that there is insufficient assurance of adequate protection for the public. The denial, citation and warning, period of probation, suspension, or revocation shall be effected and may be appealed in accordance with the requirements of 441—Chapter 7.

134.3(2) All complaints regarding the operation of a trauma care facility, or those purporting to be or operating as the same, shall be reported to the department.

134.3(3) Complaints and the investigative process shall be treated as confidential to the extent that they are protected by Iowa Code sections 22.7 and 147A.24 and chapter 272C.

134.3(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

134.3(5) Notice of denial, citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the alleged violator of denial, citation and warning, probation, suspension, or revocation shall be served by certified mail, return receipt requested, or by personal service.

134.3(6) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, news media or employer.

These rules are intended to implement Iowa Code section 147A.23.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 135
“Trauma Triage and Transfer Protocols”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.27

State or federal law(s) implemented by the rulemaking: Iowa Code section 147A.23

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliance@hhs.iowa.gov

Purpose and Summary

The purpose of the proposed chapter is to provide written directives that support decision-making by emergency medical services (EMS) clinicians in transport destination determinations for injured patients, which will improve survival after injury. The chapter will ensure that seriously injured patients are transported to the most clinically appropriate higher-level trauma centers, and patients with minor to moderate injuries can be cared for in lower-level trauma centers.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
EMS clinicians and facilities and injured patients will benefit.
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:
According to the Department’s Trauma Registry Report, over 22,000 patients received trauma services in 2021. The care of all of these patients was informed by the established triage and transfer protocols.
 - Qualitative description of impact:
The triage and transfer protocols support data-driven decision-making within the state’s trauma care system for the benefit of Iowans.

3. Costs to the State:

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

Personnel and other administrative costs are borne by the agency.

- Anticipated effect on state revenues:

There is no anticipated impact on state revenues.

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

Without this rulemaking, EMS agencies would not have written guidelines to assist in the triage and transport of injured patients to the appropriate trauma care facility, which could overburden higher-level centers, overwhelm lower-level centers, and increase mortality.

In addition, not having this rulemaking would put the Department out of compliance with Iowa Code section 147A.27(2).

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

No; the rulemaking is appropriate because it is required by law.

6. Alternative methods considered by the agency:

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

None were considered because the rulemaking is required by law.

- 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 rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 135 and adopt the following **new** chapter in lieu thereof:

CHAPTER 135
TRAUMA TRIAGE AND TRANSFER PROTOCOLS

641—135.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“*Out-of-Hospital Trauma Triage Destination Decision Protocols*” means written directives to assist in trauma and triage decision-making, established and approved by the department, to be followed by the service program.

“*Service program*” or “*service*” means the same as defined in Iowa Code section 147A.1.

“Transfer” means the process of a patient being transferred from the scene of an injury to a trauma care facility or from one trauma care facility to another.

“Trauma care facility” means the same as defined in Iowa Code section 147A.21.

“Trauma triage and transfer” means to determine the trauma care facility destination.

641—135.2(147A) Trauma triage and transfer protocols. Trauma triage and transfer protocols approved by the department assist personnel from each service program and trauma care facility. These protocols do not preclude service programs or trauma care facilities from making emergency revisions of the approved triage and transfer protocols when an incident overburdens medical care resources, causing an unnecessary delay in patient care.

135.2(1) Adoption by reference. The 2021 National Guideline for the Field Triage of Injured Patients, as amended to August 1, 2024, is incorporated by reference and adopted as the Out-of-Hospital Trauma Triage Destination Decision Guideline for the state of Iowa.

135.2(2) Revisions and modifications to the protocols adopted by reference in paragraph 135.2(1) “a” may be made upon recommendation to and approval of the department.

641—135.3(147A) Offenses and penalties. The department may deny verification as a trauma care facility or deny authorization as a service program or may give a citation and warning, place on probation, suspend, or revoke existing trauma care facility verification or service program authorization if the department finds reason to believe that the facility or service program has not been or will not be operated in compliance with Iowa Code section 147A.27 and these administrative rules. The denial, citation and warning, period of probation, suspension, or revocation shall be effected and may be appealed in accordance with the requirements of 441—Chapter 7.

These rules are intended to implement Iowa Code section 147A.23.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 136
“Trauma Registry”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.27

State or federal law(s) implemented by the rulemaking: Iowa Code section 147A.26

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliance@hhs.iowa.gov

Purpose and Summary

High-quality data from the trauma registry are critical to inform quality improvement and measure the performance of the statewide trauma system. Proposed Chapter 136 provides guidance to hospitals on high-quality data reporting of injured patients, which allows enhanced epidemiologic analysis to improve outcomes of injured patients in Iowa. This allows for focused quality improvement activities and maximizes the value of trauma benchmarking with the goal of reduced morbidity and mortality from injuries.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
The public, in general, benefits. The data collected helps inform trauma care throughout the state.
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:
All 118 hospitals in Iowa submit reports to the register. In 2022, 26,602 incidents were reported.
 - Qualitative description of impact:
Without quality injury data from hospitals, there would not be a method for analysis of opportunities for improvement within the state trauma system, data-driven decision making, and the

reduction of morbidity and mortality from injury. This includes local injury trends, severity of injury, hospital resources, and appropriate and timely care of the injured.

3. Costs to the State:

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

Personnel and other administrative costs are borne by the agency.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues.

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

Rulemaking is required under Iowa Code section 147A.27.

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

None were considered because rules are required by law.

6. Alternative methods considered by the agency:

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

None were considered because rules are required by law.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Adopt the following **new** 641—Chapter 136:

CHAPTER 136 TRAUMA REGISTRY

641—136.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“*Health care providers*” for the purpose of this chapter includes licensed physicians, advanced registered nurse practitioners, physician assistants, and registered nurses.

“*Inclusion criteria*” means criteria determined by the department of health and human services and adopted by reference to determine which trauma patients are to be included in the trauma registry.

“*Reportable patient data*” means data and definitions determined by the department and adopted by reference to be reported to the trauma registry on trauma patients meeting the inclusion criteria.

“Trauma care facility” means the same as defined in Iowa Code section 147A.21.

“Trauma patient” means a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical or chemical energy, or by the absence of heat or oxygen.

“Trauma registry” means the data repository operated by the department to collect and analyze reportable patient data on the incidence, severity, and causes of trauma, and that serves as the central registry for brain and spinal cord injuries described in rule 641—21.1(135) and farm-related injuries.

“Trauma survey team” means a group of health care providers contracted by the department to assist in verifying trauma care facilities’ compliance with trauma criteria adopted by reference in 641—subrule 134.2(3).

641—136.2(147A) Trauma registry.

136.2(1) Trauma care facilities shall submit reportable patient data electronically to the department. Data shall be submitted in the trauma registry format operated by the department. The department may require those requesting the data to pay any or all of the reasonable costs associated with furnishing the reportable patient data.

136.2(2) Quality assurance of reported data.

a. For the purpose of ensuring the completeness and quality of reportable patient data, the department or its designated trauma survey team may examine medical records to validate the accuracy of data submitted by a trauma care facility.

b. Review of medical records by the department or its designated trauma survey team may be scheduled in advance with the trauma care facility.

641—136.3(147A) Offenses and penalties. All complaints, offenses and penalties will be addressed pursuant to rule 641—134.3(147A).

These rules are intended to implement Iowa Code section 147A.26.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 137
“Trauma Education and Training”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.27

State or federal law(s) implemented by the rulemaking: Iowa Code section 147A.23

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

Licensed health care providers (i.e., registered nurses, licensed practical nurses, physicians, advanced registered nurse practitioners, and physician assistants) must be prepared with knowledge and skills to provide optimal care to injured patients. Proposed Chapter 137 provides guidance to hospitals regarding the minimum educational requirements for health care providers to deliver high-quality trauma care, which will support the well-coordinated statewide trauma system to reduce the incidence of inadequate trauma care and preventable deaths, minimize human suffering, and decrease the costs associated with preventable mortality and morbidity.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Specified health care practitioners who provide trauma care services may incur costs related to continuing education.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who receive trauma care services will benefit.
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:
The chapter requires every health care practitioner working in hospital trauma care to have the basic minimum competencies to care for injured patients. All 118 hospitals in Iowa comply with this requirement.

- Qualitative description of impact:

The rulemaking requires specified health care practitioners who provide trauma services in Iowa to have and maintain the knowledge and skills needed to provide optimal care to injured patients.

3. Costs to the State:

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

The Department will bear personnel and other administrative costs.

- Anticipated effect on state revenues:

There is no anticipated effect on state revenues.

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

Without minimum educational requirements pertaining to trauma care in hospitals, providers would not have the most current and safest, evidence-based training required to provide adequate initial care for injured patients. The risk of morbidity and mortality of trauma patients in Iowa would increase.

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

The rulemaking is appropriate as it is required by the Iowa Code.

6. Alternative methods considered by the agency:

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

None were considered.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 137 and adopt the following **new** chapter in lieu thereof:

CHAPTER 137 TRAUMA EDUCATION AND TRAINING

641—137.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“Advanced registered nurse practitioner” or “ARNP” means a nurse as defined in 655—7.1(152).

“Formal education” means education in standardized educational settings with a curriculum.

“Licensed practical nurse” or *“LPN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Physician” means an individual licensed under Iowa Code chapter 148, 150 or 150A.

“Physician assistant” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Practitioner” means a person who practices medicine or one of the associated health care professions.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Trauma” means the same as defined in Iowa Code chapter 147A.

“Trauma care facility” means the same as defined in Iowa Code chapter 147A.

“Trauma patient” means a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical or chemical energy, or by the absence of heat or oxygen.

“Verification” means the same as defined in Iowa Code chapter 147A.

641—137.2(147A) Initial trauma education requirements.

137.2(1) Trauma education is required of physicians, physician assistants, advanced registered nurse practitioners, registered nurses, and licensed practical nurses who are identified or defined as trauma team members by a trauma care facility and who participate directly in the initial resuscitation of the trauma patient.

137.2(2) Requirements for initial trauma education. Specific requirements for initial trauma education for each provider category are as follows:

a. Physicians, PAs and ARNPs shall comply with education criteria specific to the level for which the trauma care facility is verified. Physicians, PAs and ARNPs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. Physicians, PAs and ARNPs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

b. RNs and LPNs shall comply with education criteria specific to the level for which the trauma care facility is verified. RNs and LPNs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. RNs and LPNs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

641—137.3(147A) Continuing trauma education requirements. Specific requirements for continuing trauma education for each provider category are as follows:

137.3(1) Physicians, PAs and ARNPs shall comply with education criteria specific to the level for which the trauma care facility is verified. Physicians, PAs and ARNPs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. Physicians, PAs and ARNPs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

137.3(2) RNs and LPNs shall comply with education criteria specific to the level for which the trauma care facility is verified. RNs and LPNs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. RNs and LPNs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

These rules are intended to implement Iowa Code chapter 147A.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 138
“Trauma System Advisory Council”

Iowa Code section(s) or chapter(s) authorizing rulemaking: Not applicable.

State or federal law(s) implemented by the rulemaking: Iowa Code section 147A.24 and 2024 Iowa Acts, Senate File 2385

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

There is no statutory rulemaking authority for this chapter, and thus it is being repealed.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
No class of persons will specifically benefit; however, neither are any persons harmed by the rulemaking.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
This rulemaking eliminates an entire chapter consisting of ten administrative rules.
 - Qualitative description of impact:
This rulemaking eliminates a regulatory body pursuant to new legislation.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
There are no implementation or enforcement costs.
 - Anticipated effect on state revenues:
There is no anticipated effect on state revenues.

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

Not applicable.

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

Rescinding the chapter is both appropriate and required.

6. Alternative methods considered by the agency:

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

No alternative methods were considered.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 138**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 139
“Emergency Medical Services—Training Programs—Students—Complaints and Investigations”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.4

State or federal law(s) implemented by the rulemaking: Iowa Code section 147A.4

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter establishes the standards and requirements for authorization of emergency medical care training programs in the state of Iowa; establishes the requirements of the training program related to preparing students for emergency medical provider certification in the state of Iowa, and describes the authority of the Department to impose disciplinary sanctions against a training program.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
Emergency medical care training programs may incur costs associated with maintaining compliance.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans served by emergency medical care providers will benefit.
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:
There are 20 emergency medical services (EMS) training programs in Iowa.
 - Qualitative description of impact:
The rulemaking helps ensure the quality and integrity of emergency medical care training programs in Iowa.
3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
Personnel and other administrative costs are borne by the agency.
- Anticipated effect on state revenues:
There is no impact on state revenues.

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

Without regulation and standards, emergency medical care training programs could provide substandard instruction to students, which could lead to unprepared providers and diminish the quality of care to trauma patients.

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

The rulemaking is both appropriate and required by law.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
None were considered.
- Reasons why alternative methods were rejected in favor of the proposed rulemaking:
The rulemaking is both appropriate and required by law.

Small Business Impact

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

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

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

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 139 and adopt the following **new** chapter in lieu thereof:

CHAPTER 139

EMERGENCY MEDICAL SERVICES—TRAINING PROGRAMS—STUDENTS—COMPLAINTS AND INVESTIGATIONS

641—139.1(147A) Definitions.

“Advanced emergency medical technician” or “AEMT” means the same as defined in rule 641—131.1(147A,147D,272C).

“CAPCE” means the same as defined in rule 641— 131.1(147A,147D,272C).

“CEH” means the same as defined in rule 641— 131.1(147A,147D,272C).

“Certification” or “certificate” means the same as defined in rule 641— 131.1(147A,147D,272C).

“Certified” means the same as defined in rule 641— 131.1(147A,147D,272C).

“CoAEMSP” means Committee on Accreditation for the EMS Professions.

“Core continuing education” means the same as defined in rule 641— 131.1(147A,147D,272C).

“Course completion date” means the date of the final classroom session of an emergency medical care provider course.

“Course coordinator” means an individual who has been assigned by the training program to coordinate the activities of an emergency medical care provider course.

“Critical care paramedic” or *“CCP”* means the same as defined in rule 641— 131.1(147A,147D,272C).

“Emergency medical care” means any medical procedure authorized by Iowa Code chapter 147A and 641—Chapter 131.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“Emergency medical care student” or *“student”* means any individual enrolled in an EMS training program.

“Emergency medical responder” or *“EMR”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the EMR, and is currently certified by the department as an EMR.

“Emergency medical services” or *“EMS”* means the same as defined in Iowa Code section 147A.1.

“Emergency medical technician” or *“EMT”* means the same as defined in rule 641— 131.1(147A,147D,272C).

“EMS evaluator” or *“EMS-E”* means an individual who has successfully completed an EMS evaluator curriculum approved by the department and is currently endorsed by the department as an EMS-E.

“EMS instructor” or *“EMS-I”* means the same as defined in rule 641— 131.1(147A,147D,272C).

“EMS training program” or *“training program”* means a program offered by an Iowa college approved by the Higher Learning Commission, an Iowa hospital, or a service program that has received authorization from the department to conduct emergency medical care training.

“Endorsement” or *“endorsed”* means the same as defined in rule 641— 131.1(147A,147D,272C).

“Higher Learning Commission” means the independent corporation which accredits degree-granting postsecondary institutions in the north central region of the United States.

“NREMT” means the same as defined in rule 641— 131.1(147A,147D,272C).

“Out-of-state student” means any individual participating in clinical or field experience as a student in an approved out-of-state training program.

“Out-of-state training program” means an EMS training program located outside the state of Iowa that is approved by the authorizing agency of the program’s home state to conduct initial EMS training for EMR, EMT, AEMT, paramedic or other levels certified by the department.

“Outreach course coordinator” means an individual assigned by the training program to coordinate the activities of an emergency medical care provider course held outside the training program facilities.

“Paramedic” or *“PM”* means the same as defined in rule 641— 131.1(147A,147D,272C).

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician assistant” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Preceptor” means an individual assigned by the training program, clinical facility or service program to supervise EMS students while the students are completing their classroom, clinical or field experience. A preceptor shall be an emergency medical care provider certified at the level at which the preceptor is providing supervision or at a higher level or be licensed as a physician, physician assistant or registered nurse.

“Primary instructor” means an individual who is responsible for teaching the majority of an emergency medical care provider course.

“Registered nurse” or “RN” means an individual licensed pursuant to Iowa Code chapter 152.

“Service program” or “service” means the same as defined in Iowa Code section 147A.1.

“Training program director” means a health care professional (full-time educator or practitioner of emergency or critical care) assigned by the training program to direct the operation of the training program.

“Training program medical director” means a physician licensed under Iowa Code chapter 148 who is responsible for providing medical oversight to an EMS training program.

641—139.2(147A) Initial application, renewal application, inspection and approval.

139.2(1) *Initial application, inspection and approval.*

a. An applicant seeking initial authorization as an EMS training program shall complete and submit to the department an Iowa EMS training program self-assessment application. The application is available from the department upon request.

b. The department will perform an on-site inspection of the applicant’s facilities and clinical resources. The purpose of the inspection is to examine educational objectives, patient care practices, facilities and administrative practices.

c. A training program’s initial authorization is for one year.

d. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for denial of authorization.

139.2(2) *Renewal application, inspection and approval.*

a. A training program seeking renewal as an EMS training program shall complete and submit to the department the Iowa EMS training program self-assessment renewal application. The application is available from the department upon request.

b. EMS training program renewal applications will be submitted at least 90 days before the end of the current authorization period.

c. The department will complete an on-site inspection and review the self-assessment prior to the end of the current authorization period.

d. Following the on-site inspection, the department will provide the training program a renewal application report detailing the status of the application.

e. The department will authorize the training program or determine timelines for the correction of deficiencies in the renewal application.

f. If the deficiencies are not corrected within the time period established by the department, the training program is subject to disciplinary action as described in rule 641—139.8(147A).

g. A training program’s approved renewal authorization will not exceed four years.

h. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for denial of authorization.

641—139.3(147A) Training program standards, student requirements and waivers.

139.3(1) *Education standards.* A training program shall:

a. Have a sponsoring institution that has received authorization from the department to conduct emergency medical care services training.

b. Use the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021) for any courses leading to Iowa certification.

c. Use the Iowa CCP curriculum (January 2024) for courses leading to the CCP endorsement.

d. Be accredited by, or have submitted a letter of review self-study to, CoAEMSP if graduating students are at the paramedic certification level.

e. Document equivalent training and what portions of any course have been waived for equivalency. A training program may waive portions of the required emergency medical care provider training for students currently certified as emergency medical care providers or licensed in other health care professions, including but not limited to physician, nursing, physician assistant, respiratory therapist, dentistry, and military.

139.3(2) *Clinical or field experience resources.* Training programs shall:

- a. Have a mechanism to clearly identify students in the clinical or field setting, or both.
- b. Ensure that clinical experiences available are consistent with the needs of the curriculum and adequate for the number of students enrolled.
- c. Ensure that clinical affiliations that are outside of the sponsoring training program are established and confirmed in written agreements with institutions or agencies that provide clinical experience under appropriate medical direction and clinical supervision.
- d. Only allow students to perform skills and procedures in the classroom, clinical or field setting for which the students have received training with direct supervision by a preceptor designated and approved by the training program.

139.3(3) *Staff.* Training programs shall:

- a. Have a training program director who is a health care professional (full-time educator or practitioner of emergency or critical care) assigned by the training program to direct the operation of the training program.
- b. Have a training program medical director who shall, at a minimum, review the educational content of each training program curriculum, evaluate the quality of medical instruction, and supervise delivery of the curriculum by the faculty members.
- c. Have qualified faculty through academic preparation, training, and experience to teach and evaluate the courses or topics to which they are assigned. At a minimum, each course coordinator, outreach course coordinator, and primary instructor utilized by the training program shall be endorsed as an Iowa EMS instructor.

139.3(4) *Student eligibility.* Training programs shall ensure that emergency medical care students meet the following requirements:

- a. Be at least 17 years of age on the date of enrollment.
- b. Have a high school diploma or its equivalent if enrolling in an AEMT or paramedic course.
- c. Be able to speak, write and read English.
- d. Be able to meet the minimum requirements for the department- or NREMT-approved testing requirements with reasonable and appropriate accommodations for those persons with documented disabilities, as required by the Americans with Disabilities Act (ADA) as amended to August 1, 2024.
- e. Be currently certified, at a minimum, as an EMT if enrolling in an AEMT or paramedic course.
- f. Be a current emergency medical care provider, RN, PA, or physician.

139.3(5) *Students.* Training programs shall:

- a. Have defined processes for review of academic history, criminal history, and health-related issues for the admission of students.
- b. Have a process to evaluate students on a recurring basis and with sufficient frequency to provide both the student and training program faculty with valid and timely indicators of the student's progress and achievement of the competencies and objectives stated within the program's curriculum.
- c. Have student guidance procedures that include documentation of regular and timely discussions with qualified faculty or counselors.
- d. Maintain student records for each student enrolled in each program.
- e. Notify the NREMT of each student's successful completion of a training course to ensure NREMT cognitive examination eligibility.
- f. Verify that a student completes all training program requirements before being eligible to attempt the department- or NREMT-approved testing requirements.
- g. Verify that a student completes all training program coursework and completes the department- or NREMT-approved testing requirements before applying to the department for an initial Iowa emergency medical care provider certification.
- h. Ensure that students only perform skills or procedures learned in the training program until an Iowa emergency medical care provider certification is obtained.

i. Ensure that a student is not substituted for the regular personnel of any affiliated medical facility or service program but may be employed while enrolled in the training program.

139.3(6) *Financing and administration.* Training programs shall:

a. Have sufficient equipment and supplies to be used in the provision of instruction. The equipment and supplies shall be available and consistent with the needs of the curriculum and adequate for the number of students enrolled.

b. Have sufficient classrooms, laboratories, and administrative offices and facility design to accommodate the number of students in the program and the supporting faculty.

c. Notify the department, in writing, of any change in ownership or control of the training program.

d. Have liability insurance or offer liability insurance to enrolled students.

641—139.4(147A) Out-of-state training programs.

139.4(1) *Application, inspection and approval.*

a. An out-of-state training program shall complete and submit to the department for review and approval the out-of-state training program self-assessment application. The application is available from the department upon request.

b. An out-of-state training program's approval by the department shall not exceed four years.

c. An out-of-state training program seeking initial or renewal approval and graduating students at the paramedic level must also be accredited by, or have submitted a letter of review self-study to, CoAEMSP.

d. An out-of-state training program shall be limited to utilization of clinical sites or field sites, or both, within Iowa.

e. An authorized out-of-state training program shall provide the department with a current roster of students who will be participating in the clinical or field experience within the state of Iowa and, for each program, the sites where the students will be participating. This roster will be provided prior to commencement of any clinical or field experience.

f. An out-of-state training program shall provide documentation of liability insurance for each student participating in the clinical or field setting within the state of Iowa.

g. Failure to comply with these requirements may lead to disciplinary action or denial of utilization of clinical or field sites in Iowa.

h. The department may perform an on-site inspection of the out-of-state training program's facilities and clinical and field resources as part of the initial or renewal review process.

i. The department, without prior notification, may make inspections at times, at places and under such circumstances as it deems necessary to ensure compliance with Iowa Code chapter 147A and these rules.

j. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for disciplinary action regarding training program approval.

k. Representatives of the training program may be required to meet with the department at the time the application and inspection report are discussed.

l. A written report of department action and the department inspection report will be sent to the training program.

m. A training program shall notify the department, in writing, of any change in ownership or control within 30 days.

139.4(2) Reserved.

641—139.5(147A) Failure to comply with rules. Failure of a training program to comply with these rules may result in disciplinary action according to rule 641—139.8(147A).

641—139.6(147A) Temporary waivers. If during a period of authorization there is some occurrence that temporarily causes a training program to be in noncompliance with these rules, the department may grant a temporary waiver.

139.6(1) Waivers of these rules may be granted by the department to a currently authorized training program.

139.6(2) Requests for waivers apply only to the training program requesting the waiver and apply only to those requirements and standards for which the department is responsible.

139.6(3) A training program can apply for a waiver in accordance with 441—Chapter 6.

641—139.7(147A) Continuing education providers—approval, recordkeeping and inspection.

139.7(1) A training program may conduct continuing education courses utilizing training program instructors.

139.7(2) Each training program shall assign a sponsor number to each core continuing education course using an assignment system approved by the department.

139.7(3) Course approval shall be completed prior to the course being offered.

139.7(4) Each training program shall maintain a participant record that includes, at a minimum, each participant's:

- a.* Name.
- b.* Address.
- c.* Certification number.
- d.* Course sponsor number.
- e.* Course instructor.
- f.* Date of course.
- g.* CEHs awarded.

139.7(5) The department may request additional information or inspect the records of any continuing education provider who is currently approved or who is seeking approval.

641—139.8(147A) Discipline—denial, citation and warning, probation, suspension, or revocation of training program approval or renewal.

139.8(1) This rule is not subject to waiver pursuant to 441—Chapter 6 or any other provision of law.

139.8(2) Method of discipline. The department has the authority to impose the following disciplinary sanctions against a training program:

- a.* Issue a citation and warning.
- b.* Impose a period of probation under specific conditions.
- c.* Prohibit permanently, until further order of the department, or for a specific period, a program's ability to engage in specific procedures, methods, acts or activities incident to the practice of the profession.
- d.* Suspend an authorization until further order of the department or for a specific period.
- e.* Deny an application for authorization.
- f.* Revoke an authorization.
- g.* Impose such other sanctions as allowed by law and as may be appropriate.

139.8(3) The department may impose any of the disciplinary sanctions provided in subrule 139.8(2) when it finds that the training program or applicant has failed to meet the applicable provisions of these rules or has committed any of the following acts or offenses:

- a.* Fraud in procuring approval or renewal.
- b.* Falsification of training or continuing education records or failure to document training or continuing education.
- c.* Suspension or revocation of approval to provide emergency medical care training or other disciplinary action taken pursuant to Iowa Code chapter 147A. A certified copy of the record or order of suspension, revocation or disciplinary action is conclusive or prima facie evidence.

- d.* Engaging in any conduct that subverts or attempts to subvert a department investigation.
- e.* Failure to respond within 30 days of receipt of communication from the department that was sent by registered or certified mail.
- f.* Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.
- g.* Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.
- h.* Submission of a false report of continuing education or failure to submit the quarterly report of continuing education.
- i.* Knowingly aiding, assisting or advising a person to unlawfully practice EMS.
- j.* Representing itself as an approved training program or continuing education provider when approval has been suspended or revoked or when approval has lapsed or has been placed on inactive status.
- k.* Using an unqualified individual as an instructor or evaluator.
- l.* Allowing verbal or physical abuse of a student or staff.
- m.* Failing to verify registration of a student with the department within the timeline established by the department or allowing an unregistered student to function in a clinical environment.
- n.* Sexually harassing a patient, student or coworker. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature communicated in person, in writing, via a third person or through electronic communication.
- o.* Betrayal of a professional confidence.
- p.* Engaging in a professional conflict of interest.
- q.* Discrimination. A training program or continuing education provider shall not practice, condone, or facilitate discrimination against a patient, student, or supervisee on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability, diagnosis, or social or economic status.
- r.* Failure to comply with the 2015 Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions published by the Commission on Accreditation of Allied Health Education Programs.

641—139.9(147A) Complaints, investigations and appeals.

139.9(1) All complaints regarding an emergency medical care student, training programs or continuing education providers or those purporting to be or operating as the same shall be reported to the department in writing.

139.9(2) Any emergency medical care provider, emergency medical care student, training program or continuing education provider who has knowledge of an emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall report such information to the department.

139.9(3) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

139.9(4) A determination of mental incompetence by a court of competent jurisdiction automatically suspends a certificate for the duration of the certificate unless the department orders otherwise.

139.9(5) Notice of denial, issuance of a citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 147A.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 140
“Emergency Medical Services System Development Grants Fund”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.25

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 147A

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hs.iowa.gov

Purpose and Summary

This proposed chapter provides clarity and a process for emergency medical services (EMS) system development grant requirements.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

There are no costs associated with the rulemaking.

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

County EMS associations that apply for EMS development grants, as well as the Iowans they serve, benefit.

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:

The Department has offered \$750,000 in contracts for each of the past two years. The system development grant funds are typically underspent and have funds left over each year that are nonreverting. The limiting language in statute for use of funds has created a barrier for EMS programs to spend the full dollar amount of the contracts. Approximately 85 percent of the funds contracted have been spent over the last three years on average.

- Qualitative description of impact:

Optimal EMS care is limited in many parts of the state. With health care delivery in transition, access to quality trauma and emergency medical care continues to challenge Iowa’s rural

communities. The goal of an emergency medical care system is to coordinate the medical needs of a sick or injured person with an integrated system of optimal and cost-effective care. The result of a well-coordinated emergency medical care system is to reduce incidence of inadequate medical care and preventable deaths, minimize human suffering, and decrease the costs associated with preventable mortality and morbidity. Providing grants to support the development of the emergency medical care system in Iowa will achieve these goals while meeting the unique needs of the rural residents of the state.

3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:
Part of one full-time equivalent position is utilized for contracting and paying invoices.
- Anticipated effect on state revenues:

The grants are supported by legislative appropriations to the Emergency Medical Services Fund. This rulemaking does not impact the fund; however, for each of the last two years \$750,000 has been contracted to county EMS associations with approximately 85 percent of the funds contracted having been spent over the last three years.

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

Without this chapter, county EMS associations would not have guidance about which types of costs are eligible for grant funding.

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

The rulemaking is both appropriate and required by law.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:
None were considered.
- Reasons why alternative methods were rejected in favor of the proposed rulemaking:
The rulemaking is both appropriate and required by law.

Small Business Impact

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

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

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

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 140 and adopt the following **new** chapter in lieu thereof:

CHAPTER 140
EMERGENCY MEDICAL SERVICES SYSTEM DEVELOPMENT GRANTS FUND

641—140.1(135) Definitions. For the purpose of these rules, the following definitions apply:

“*Ambulance service*” means the same as defined in 641—132.1(147A).

“*CEHs*” means the same as defined in 641—131.1(147A,147D,272C).

“*Continuing education*” means the same as defined in 641—131.1(147A,147D,272C).

“*County EMS association*” means a countywide group of EMS providers and various agency and organization representatives and consumers who provide leadership for the local EMS system on needs and objectives. The county EMS association should also include representatives of services located in a neighboring county if service is provided on a regular basis to residents of the county receiving funding.

“*Emergency medical care provider*” means the same as defined in Iowa Code section 147A.1.

“*Emergency medical services*” or “*EMS*” means the same as defined in Iowa Code section 147A.1.

“*EMS course*” means a course for emergency medical care personnel pursuant to Iowa Code section 147A.4(2).

“*Infrastructure*” means those elements that make up an EMS system.

“*Nontransport service*” means nontransport service as defined in 641—132.1(147A).

“*Regional EMS council*” means a multicounty nonprofit corporation whose purpose is to facilitate EMS development on a regional basis.

“*Service program*” means service program as defined in Iowa Code section 147A.1.

“*Strategic plan*” means a document produced via a multiagency effort to evaluate and define needs and goals to improve the local EMS system.

“*Training*” means EMS-related courses designed and intended for EMS providers and includes any item used in training, including but not limited to slides, films, mannequins, emergency care devices, books and other items pertinent and necessary for training purposes.

641—140.2(135) County EMS associations. Each county will have a county EMS association, council or board to develop and maintain the countywide EMS system strategic plan and to provide leadership on related EMS system development funding needs and objectives.

641—140.3(135) County EMS system development grants. Grants for EMS system development proposals at the regional, county, and local level are available through a grant process from the department to county boards of supervisors or local boards of health for equipment, training, and support of infrastructure needs as identified in the countywide EMS strategic plan and the department system standards. County boards of supervisors or local boards of health shall not take any administrative fee from these funds to support their work under this rule. County recipients of funds may subcontract work under this agreement to a county EMS association. Funds for training will be used to train members of a service program that provides service on a regular basis to residents of the county being funded. Funds for equipment require a \$1 match of regional, county, or local funds for each \$1 of EMS system development grant funds.

140.3(1) Eligible costs. Costs eligible for EMS system development grant expenditures as defined in the request for proposal (RFP) include:

a. Training.

(1) Reimbursement for initial training tuition, fees and materials up to an amount that is the lowest fee charged by the training entity following successful completion of an EMS course. Practical and written examination fees may also be included.

(2) Payment of continuing education tuition, fees and materials. Education provided by an EMS program for the general public is an allowable expense.

- (3) Payment for EMS training aids.
- b.* Other equipment as defined by the RFP.
- c.* Infrastructure support.
- (1) Development and enhancement of EMS systems.
- (2) Office equipment and supplies necessary to coordinate a countywide EMS system.
- (3) Personnel services for staffing to provide countywide continuous quality improvement and medical direction.

The title to any EMS equipment purchased with these funds does not lie with the department but will be determined by the county.

140.3(2) *Ineligible costs.* Costs not eligible for funding include:

- a.* Certification/recertification fees.
- b.* Building and construction costs.
- c.* Debt amortization.
- d.* Land.
- e.* Rent.
- f.* Utilities.
- g.* Vehicles including ambulances, fire apparatus, boats, rescue/first-response vehicles, snowmobiles and vehicle parts.

These rules are intended to implement Iowa Code section 135.25.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 142
“Out-of-Hospital Do-Not-Resuscitate Orders”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 144A.7A

State or federal law(s) implemented by the rulemaking: Iowa Code section 144A.7A

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

These proposed rules direct EMS providers and service programs on the processes for the recognition of out-of-hospital do-not-resuscitate (OOH DNR) orders or identifiers and implementation of the OOH DNR protocol. In addition, these rules set forth guidelines for consideration by health care providers and organizations to help ensure uniform and orderly understandings, processes and procedures for the use and implementation of OOH DNR orders consistent with the provisions of Iowa Code chapter 144A.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no costs associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans with terminal conditions who desire to have OOH DNR orders in place will benefit.
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:
The OOH DNR form is open and accessible for public use. It is unknown how many Iowans utilize the OOH DNR order. EMS providers comply with orders when in use.
 - Qualitative description of impact:

The OOH DNR order provides Iowans who do not want to be resuscitated an option to let EMS providers know their wishes. EMS providers comply with OOH DNR orders according to this administrative rule.

3. Costs to the State:

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

Personnel and other administrative costs will be borne by the Department.

- Anticipated effect on state revenues:

There will be no impact on state revenues.

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

Without this guidance for health care providers, Iowans who do not want to be resuscitated may not have the opportunity to have their wishes fulfilled.

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

No, the rulemaking is appropriate and required by law.

6. Alternative methods considered by the agency:

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

No other methods were considered.

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

The statute directs the Department to promulgate rules.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 142 and adopt the following **new** chapter in lieu thereof:

CHAPTER 142
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

641—142.1(144A) Definitions. For the purpose of these rules, the following definitions apply:

“*Adult*” means an individual 18 years of age or older.

“*Attending physician*” means a physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

“Attending physician assistant” means the physician assistant selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

“Comfort care” means care within the scope of the health care provider’s training and certification to alleviate pain and suffering but does not include resuscitative measures.

“Emergency medical care” means such medical procedures as:

1. Administration of intravenous solutions.
2. Intubation.
3. Performance of cardiac defibrillation and synchronized cardioversion.
4. Administration of emergency drugs as provided by rule by the department.
5. Any other medical procedure approved by the department, by rule, as appropriate to be performed by emergency medical care providers who have been certified in that procedure.

“EMS provider” means an emergency medical care provider as defined in Iowa Code section 147A.1.

“Health care provider” means a person, including an emergency medical care provider, who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

“Hospital” means any hospital licensed under the provisions of Iowa Code section 135B.1.

“Life-sustaining procedure” means any medical procedure, treatment, or intervention, including resuscitation, which utilizes mechanical or artificial means to sustain, restore or supplant a spontaneous vital function, and when applied to a patient in a terminal condition, would serve only to prolong the dying process. “Life-sustaining procedure” does not include the provision of nutrition or hydration except when required to be provided parenterally or through intubation or the administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

“Medical direction” means direction, advice, or orders provided by a medical director or supervising physician.

“Medical director” means any physician licensed under Iowa Code chapter 148 who is responsible for overall medical direction of the service program and who has completed a medical director workshop, sponsored by the department, within one year of assuming duties.

“Online medical direction” means immediate medical direction provided directly to service program emergency medical care providers, in accordance with written parameters and protocols, by the medical director or supervising physician, either on scene or by any telecommunications system.

“Out-of-hospital do-not-resuscitate identifier” or *“OOH DNR identifier”* means a durable yet easily removable unique identification approved by the department and worn by a patient who has an out-of-hospital do-not-resuscitate order.

“Out-of-hospital do-not-resuscitate order” or *“OOH DNR order”* means a written order on a form approved by the department, signed by an attending physician, executed in accordance with the requirements of Iowa Code section 144A.7A and issued consistent with Iowa Code section 144A.2, that directs the withholding or withdrawal of resuscitation when an adult patient in a terminal condition is outside the hospital.

“Out-of-hospital do-not-resuscitate protocol” or *“OOH DNR protocol”* means the statewide protocol approved by the department and intended to avoid unwarranted resuscitation by emergency medical care providers when a valid out-of-hospital do-not-resuscitate order or identifier is encountered.

“Patient” means any individual who is sick, injured, or otherwise incapacitated.

“Physician” means any individual licensed under Iowa Code chapter 148.

“Physician assistant” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Qualified patient” means any patient who is an adult as defined in Iowa Code section 144A.2.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Resuscitation” means any medical intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a spontaneous vital function, including but not limited to chest

compression, defibrillation, intubation, and emergency drugs intended to alter cardiac function or otherwise to sustain life.

“*Service program*” or “*service*” means any medical care ambulance service or nontransport service that has received authorization by the department.

“*Supervising physician*” means any physician licensed under Iowa Code chapter 148.

“*Terminal condition*” means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.

641—142.2(144A,147A) Responsibilities of the department.

142.2(1) *OOH DNR physician or physician assistant order.* The department designates the OOH DNR order form contained in Appendix A as the uniform OOH DNR order form to be used statewide. If an attending physician or attending physician assistant issues an OOH DNR order for a qualified patient, the physician or physician assistant must use the form contained in Appendix A.

142.2(2) *OOH DNR personal identifier.* The department designates the identifier supplied by MedicAlert® as the uniform personal identifier to be used for mobile qualified patients statewide. Instructions for obtaining a uniform personal identifier are contained in Appendix A.

142.2(3) *OOH DNR protocol.* The department designates the OOH DNR protocol contained in Appendix B as the uniform protocol to be used by EMS providers in implementing an OOH DNR order.

142.2(4) *Appendix A and Appendix B forms.* Forms referenced in subrules 142.3(1) through 142.3(3) are available through the department’s website or by request.

641—142.3(144A,147A) EMS providers.

142.3(1) *Uniform protocol.* EMS providers shall act in accordance with the department’s OOH DNR protocol when implementing an OOH DNR order. EMS service programs shall incorporate the OOH DNR protocol as part of their service protocols and, using educational materials consistent with the curriculum developed and approved by the department, shall inform and educate EMS providers on the protocol’s requirements as well as the requirements of Iowa Code chapter 144A and these rules.

142.3(2) *Responsibility of the EMS provider.* The EMS provider responding outside a hospital as a member of a service program shall:

- a.* Evaluate the patient’s status and needs through an assessment consistent with the provider’s training and certification.
- b.* Determine the existence of an OOH DNR order or that the patient is wearing an OOH DNR identifier.
- c.* Honor the OOH DNR order or OOH DNR identifier worn by the patient.
- d.* Discontinue resuscitation if the OOH DNR order or OOH DNR identifier worn by the patient is discovered after resuscitation has begun.
- e.* Follow the OOH DNR protocol.
- f.* Provide comfort care to the patient at all times.
- g.* Contact on-line medical direction for further instructions as necessary to provide appropriate patient care.
- h.* If uncertainty exists regarding the validity or applicability of the OOH DNR order or identifier, the EMS provider shall provide the necessary and appropriate resuscitation.
- i.* Document compliance or noncompliance with the OOH DNR order and the reasons for not complying with the order, including evidence that the order was revoked or uncertainty regarding the validity or applicability of the order.

641—142.4(144A) Guidelines for non-EMS health care providers, patients, and organizations. In order to encourage understanding and implementation of OOH DNR orders and protocols throughout

Iowa and honor a qualified patient's wishes and intent regarding the provision of life-sustaining procedures in an out-of-hospital setting consistent with the requirements of Iowa Code chapter 144A, the following guidelines should be considered.

142.4(1) *Attending physicians or attending physician assistants who issue OOH DNR orders.* The attending physician or attending physician assistant should ensure that the following are accomplished:

- a.* Establish that the patient is qualified because the patient:
 - (1) Is an adult; and
 - (2) Has a terminal condition.
- b.* Explain to the patient or the individual legally authorized to act on the patient's behalf the implications of an OOH DNR order.
- c.* If the qualified patient or individual legally authorized to act on the patient's behalf decides that the patient should not be resuscitated, the attending physician or attending physician assistant may issue the OOH DNR order on the prescribed uniform order form. The order will direct health care providers to withhold or withdraw resuscitation.
- d.* Explain to the qualified patient or the individual legally authorized to act on the patient's behalf how the OOH DNR order is revoked.
- e.* Include a copy of the order in the qualified patient's medical record.
- f.* Provide a copy of the order to the qualified patient or the individual legally authorized to act on the patient's behalf.

142.4(2) *Qualified patients or legally authorized persons.* A qualified patient or a person legally authorized to act on a qualified patient's behalf should:

- a.* Make an informed decision concerning resuscitation in the face of a terminal condition.
- b.* Ensure that the qualified patient's family members are aware of this decision and inform them of the location of the OOH DNR order and the purpose of an OOH DNR identifier.
- c.* Understand the process for revocation as described in rule 641—142.5(144A).

142.4(3) *Non-EMS health care providers.* A non-EMS health care provider contemplating resuscitation for a patient should:

- a.* Evaluate the patient's status and needs through an assessment consistent with the provider's training, certification and licensure.
- b.* Determine that the presenting condition is within the scope of the patient's terminal condition and is not the result of a motor vehicle collision, fire, mass casualty or other cause of a sudden accident or injury.
- c.* Determine the existence of an OOH DNR order or that the patient is wearing an OOH DNR identifier.
- d.* Honor the OOH DNR order or OOH DNR identifier worn by the patient.
- e.* Discontinue resuscitation if the OOH DNR order or OOH DNR identifier worn by the patient is discovered after resuscitation has begun.
- f.* Provide comfort care to the patient at all times.
- g.* If uncertainty exists regarding the validity or applicability of the OOH DNR order or identifier, the health care provider shall provide the necessary and appropriate resuscitation.
- h.* Document compliance or noncompliance with the OOH DNR order and the reasons for not complying with the order, including evidence that the order was revoked or uncertainty regarding the validity or applicability of the order or OOH DNR identifier.

142.4(4) *Hospitals.* A hospital:

- a.* Is not precluded from honoring an OOH DNR order entered in accordance with this chapter and in compliance with established hospital policies and protocols.
- b.* Should, to avail itself of the immunities provided within Iowa Code chapter 142, establish such policies and protocols to address an OOH DNR order or identifier encountered on a person who presents to the emergency department or in any other area within the facility if the person presents as a patient or visitor.

c. Should integrate policies and procedures with the OOH DNR protocol for hospital-based ambulance service programs, if present.

142.4(5) *Other health care organizations.* A nursing home, home health care agency, hospice, or other health care organization should establish policies and protocols consistent with these rules to address admitted patients who have OOH DNR orders.

641—142.5(144A) Revocation of the out-of-hospital do-not-resuscitate order. An OOH DNR order is deemed revoked at any time that a patient, or an individual authorized to act on the patient's behalf as designated on the OOH DNR order, is able to communicate in any manner the intent that the order be revoked, without regard to the mental or physical condition of the patient. A revocation is only effective as to the health care provider upon communication to that provider by the patient, an individual authorized to act on the patient's behalf as designated in the OOH DNR order, or by another person to whom the revocation is communicated by the patient.

641—142.6(144A) Personal wishes of family members or other individuals who are not authorized to act on the patient's behalf. The personal wishes of family members or other individuals who are not authorized in the order to act on the patient's behalf cannot supersede a valid OOH DNR order.

641—142.7(144A) Transfer of patients.

142.7(1) An attending physician or attending physician assistant who is unwilling to comply with an OOH DNR order or who is unwilling to comply with the provisions of Iowa Code section 144A.7A shall take all reasonable steps to effect the transfer of the patient to another physician or physician assistant.

142.7(2) If the policies of a hospital, nursing home, home health care agency, hospice or other health care organization preclude compliance with the OOH DNR order of a qualified patient, the provider shall take all reasonable steps to effect the transfer of the patient to an organization in which the provisions of Iowa Code section 144A.7A can be carried out.

641—142.8(144A) Application to existing orders.

142.8(1) An OOH DNR order or similar order executed prior to September 10, 2003, is valid and shall be honored in accordance with the then-applicable provisions of the law.

142.8(2) Health care providers may honor an OOH DNR order or identifier from another state if it can be validated and applied in a manner consistent with the OOH DNR order or identifier prescribed in these rules. In cases where there is uncertainty, clarification should be sought through on-line medical direction or resuscitation efforts should be initiated.

These rules are intended to implement Iowa Code sections 144A.7A and 147A.4.

APPENDIX A

**Iowa Department of Health and Human Services
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER
(Please type or print)**

Date of Order: ____/____/____

Patient Information:

Name: (Last)____(First)____(Middle)____

Address:____(City)____(Zip)____

Date of Birth: ____/____/____ Gender (Circle): M or F

Name of Hospice or Care Facility (if applicable): _____

Attending Physician or Physician Assistant Order

As the attending physician or attending physician assistant for the above-named patient, I certify that this individual is over 18 years of age and has a terminal diagnosis. After consultation with this patient (or the patient's legal representative), I hereby direct any and all health care providers, including qualified emergency medical services (EMS) personnel, to withhold or withdraw the following life-sustaining procedures in accordance with Iowa law (Iowa Code chapter 142A):

- Cardiopulmonary Resuscitation/Cardiac Compression (Chest Compressions).
- Endotracheal Intubation/Artificial or Mechanical Ventilation (Advance Airway Management).
- Defibrillation and Related Procedures.
- Use of Resuscitation Drugs.

This directive does NOT apply to other medical interventions for comfort care.

Signature of Attending Physician (MD, DO) or
Attending Physician Assistant

____/____/____
Date

**Printed Name of Attending Physician or Attending
Physician Assistant**

(____)____-____
**Physician's or Physician Assistant's
Telephone (Emergency)**

To the extent that it is possible, a person designated by the patient may revoke this order on the patient's behalf. If the patient wishes to authorize any other person(s) to revoke this order, the patient MUST list those persons' names below:

Name: _____

Name: _____

Name: _____

Name: _____

Patients, please note: Directions for obtaining a uniform identifier are listed on the back of this form. The uniform identifier is the key way the health care provider and/or EMS personnel can quickly recognize that you have an Out-of-Hospital Do-Not-Resuscitate order. If you are not wearing an identifier, the health care provider and/or EMS personnel may not realize that you do not want to be resuscitated.

Physicians or physician assistants, please note: Information regarding the completion of an Out-of-Hospital Do-Not-Resuscitate order is on the back of this form.

APPENDIX A

Directions for obtaining a uniform identifier:

The uniform identifier may be obtained through MedicAlert®¹, which requires:

1. A completed MedicAlert® application, which is available in physician or physician assistant offices or through MedicAlert® by phoning (800)432-5378 or the website www.medicalert.org, and fee.
2. A copy of this completed OOH DNR order, which must accompany the MedicAlert® application or be sent to MedicAlert® prior to the identifier's being mailed.

¹*MedicAlert® is a nonprofit 501C membership organization.*

Suggested guidelines for physicians or physician assistants:

1. Please review the Iowa Out-of-Hospital Do-Not-Resuscitate order and related protocol with the patient/patient's legal representative(s). The following points may be helpful:

- Patient/patient's legal representative(s) listed on this order must understand the significance of this order, that in the event the patient's heart or breathing stops or malfunctions, the anticipated result of this order is death.
- Patient/patient's legal representative(s) listed on this order may revoke this directive at any time. However, the desire to revoke must be communicated to the EMS or other health care professionals at the scene.
- It is important to emphasize that this order does not apply to medical interventions to make the patient more comfortable.
- The importance of wearing the uniform identifier for those qualified patients who would benefit from the mobility this offers should be stressed. It is also helpful to walk patients through the process they must follow to acquire the identifier.

2. Provide a copy of this order to the patient/patient's legal representative(s) listed on this order and place the original in the patient's medical records.

The OOH DNR Order form is available through the department's website.

APPENDIX B

EMS OUT-OF-HOSPITAL DO-NOT-RESUSCITATE PROTOCOL

Purpose: This protocol is intended to avoid unwarranted resuscitation by emergency care providers in the out-of-hospital setting for a *qualified patient*.¹ There must be a valid Out-of-Hospital Do-Not-Resuscitate (OOH DNR) order signed by the qualified patient's attending physician or physician assistant or the presence of the OOH DNR identifier indicating the existence of a valid OOH DNR order.

No resuscitation: Means withholding any medical intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a spontaneous vital function, including but not limited to:

1. Chest compressions,
2. Defibrillation,
3. Esophageal/tracheal/double-lumen airway; endotracheal intubation, or
4. Emergency drugs to alter cardiac or respiratory function or otherwise sustain life.

Patient criteria: The following patients are recognized as qualified patients to receive no resuscitation:

1. The presence of the uniform OOH DNR order or uniform OOH DNR identifier, or
2. The presence of the attending physician or attending physician assistant to provide direct verbal orders for care of the patient.

The presence of a signed physician or physician assistant order on a form other than the uniform OOH DNR order form approved by the department may be honored if approved by the service program EMS medical director. However, the immunities provided by law apply only in the presence of the uniform OOH DNR order or uniform OOH DNR identifier. When the uniform OOH DNR order or uniform OOH DNR identifier is not present, contact must be made with on-line medical control and on-line medical control must concur that no resuscitation is appropriate.

Revocation: An OOH DNR order is deemed revoked at any time that a patient, or an individual authorized to act on the patient's behalf as listed on the OOH DNR order, is able to communicate in any manner the intent that the order be revoked. The personal wishes of family members or other individuals who are not authorized in the order to act on the patient's behalf shall not supersede a valid OOH DNR order.

Comfort Care (♥): When a patient has met the criteria for no resuscitation under the foregoing information, the emergency care provider should continue to provide that care which is intended to make the patient comfortable (a.k.a. ♥Comfort Care). Whether other types of care are indicated will depend upon individual circumstances for which medical control may be contacted by or through the responding ambulance service personnel.

♥Comfort Care may include but is not limited to:

1. Pain medication.
2. Fluid therapy.
3. Respiratory assistance (oxygen and suctioning).

¹*Qualified patient* means an adult patient determined by an attending physician or attending physician assistant to be in a terminal condition for which the attending physician or attending physician assistant has issued an Out-of-Hospital DNR order in accordance with the law. (Rule 641—142.1(144A), definitions)

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 143
“Automated External Defibrillator Maintenance”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 613.17

State or federal law(s) implemented by the rulemaking: Iowa Code section 613.17

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The proposed rules set the standards under which a person or entity that owns, manages, or is otherwise responsible for the premises on which an automated external defibrillator is located, who in good faith renders emergency care or assistance without compensation, shall not be liable for any civil damages for acts or omissions occurring at the place of an emergency or accident or while the person is in transit to or from the emergency or accident or while the person is at or being moved to or from an emergency shelter unless such acts or omissions constitute recklessness or willful and wanton misconduct if the person or entity maintains the automated external defibrillator in a condition for immediate and effective use at all times.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
There are no anticipated costs associated with the rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
Iowans who may require an automated external defibrillator to be used on them will benefit.
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:
Unknown.
 - Qualitative description of impact:

Provides an incentive for persons or entities that own, manage, or are otherwise responsible for the premises on which an automated external defibrillator is located to maintain the automated external defibrillator in a condition for immediate and effective use at all times.

3. Costs to the State:

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

None.

- Anticipated effect on state revenues:

None.

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

Without the rulemaking, the Department would not be following the law.

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

No other methods were considered because the Department was directed to establish rules.

6. Alternative methods considered by the agency:

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

None.

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

No other methods were considered since the Department was directed to establish rules.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 143 and adopt the following **new** chapter in lieu thereof:

CHAPTER 143
AUTOMATED EXTERNAL DEFIBRILLATOR MAINTENANCE

641—143.1(613) Definition. For the purposes of these rules, the following definition applies:

“Automated external defibrillator” or “AED” means an external semiautomatic device that determines whether defibrillation is required.

641—143.2(613) AED maintenance. The person or entity maintaining the AED shall:

143.2(1) Ensure that the AED is maintained and inspected in accordance with the manufacturer's guidelines.

143.2(2) Ensure that the AED is programmed to conform to nationally accepted guidelines for treatment of cardiac arrest patients.

These rules are intended to implement Iowa Code section 613.17.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 144
“Emergency Medical Services—Air Medical Service Program Authorization”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 147A.4

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 147A

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking rescinds Chapter 144.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
No specific class of persons will benefit from this rulemaking, but neither will any be harmed.
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:
The elimination of one administrative chapter.
 - Qualitative description of impact:
Rescinding this chapter and moving relevant language to 641—Chapter 132 will create a more streamlined, all-encompassing emergency medical services program authorization chapter.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
There will be no costs with this rulemaking.
 - Anticipated effect on state revenues:
There will be no impact on state revenues with this rulemaking.

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

Leaving the chapter in place leaves fragmented emergency medical services program authorization rules that otherwise would be found in two different chapters.

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

No, combining 641—Chapters 132 and 144 is congruent with the intent of Executive Order 10.

6. Alternative methods considered by the agency:

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

None.

- 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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 144**.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 150
“Iowa Regionalized System of Perinatal Health Care”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 135.11

State or federal law(s) implemented by the rulemaking: Iowa Code section 135.11

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The Iowa Code requires the Department to adopt rules to develop and maintain the statewide perinatal program. The purpose is so health care providers can rapidly access specialty services for at-risk pregnant women and newborns. This helps providers, especially in rural areas, to know what physical facilities, equipment, medical personnel and hospital systems the birthing hospital has, so an appropriate referral of the patient can be made quickly. There are Levels I, II, III and IV for maternal level of care and Levels I, II, III and IV for neonatal care. Level I hospitals provide basic obstetrical and newborn care. Level IV is the highest level of care for the most complex and critically ill pregnant women and infants.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
None have been identified.
 - Classes of persons that will benefit from the proposed rulemaking:
People in need of maternal and neonatal care and medical providers will benefit.
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:
High-risk infants, specifically very low birth weight (less than 1,500 grams) or very premature (less than 32 weeks gestational age), have higher mortality rates when born outside hospitals with the

most specialized levels of care (Level III or Level IV). Although they represent less than 2 percent of U.S. births, 55 percent of infant deaths occur among very low birth weight infants.

- Qualitative description of impact:

These rules are necessary to provide a framework for defining and evaluating the level of perinatal services offered by a hospital and to provide Iowa perinatal patients with appropriate maternal and neonatal care as close to their homes as possible.

3. Costs to the State:

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

The Department will incur personnel costs to support the execution of the procedures described in this chapter.

- Anticipated effect on state revenues:

No impact has been identified.

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

Without this chapter, more high-risk infants would probably die. Maintaining and strengthening perinatal regionalization systems and monitoring the percent of high-risk infants born outside of Level III centers could potentially save thousands of infants' lives every year. There is ongoing research to determine if maternal mortality rates are reduced as well when high-risk pregnant women are cared for at Level III and Level IV centers.

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

None have been identified.

6. Alternative methods considered by the agency:

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

The Department supports rules necessary to develop and maintain the statewide perinatal program in accordance with the Iowa Code. These rules provide an additional framework, but only within the scope provided and as defined in the Iowa Code.

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

This chapter implements the statewide perinatal program in accordance with the Iowa Code.

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?

Not applicable.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 150 and adopt the following **new** chapter in lieu thereof:

CHAPTER 150
IOWA REGIONALIZED SYSTEM OF PERINATAL HEALTH CARE

641—150.1(135) Participation and designation. Hospitals within the state must determine whether to participate in Iowa’s regionalized system of perinatal health care and will select the hospital’s level of participation in the regionalized system. A hospital having determined to participate in the regionalized system must comply with the rules appropriate to the levels of participation for maternal care and neonatal care selected by the hospital. Maternal levels of designation and neonatal levels of designation are evaluated separately, and a hospital may have a level of designation for maternal care that is different from the level of designation for neonatal care; however, a pregnant woman should be cared for at the hospital that best meets both her and her newborn infant’s needs.

641—150.2(135) Definitions.

“*Categorization*” means a preliminary determination by the department that a hospital is capable of providing maternal care and neonatal care at Level I, Level II, Level III, or Level IV.

“*Certificate of verification*” means a document awarded by the department that identifies a hospital’s level of maternal care and neonatal care at Level I, Level II, Level III, or Level IV and the term of verification at that level.

“*Hospital*” means a facility licensed under Iowa Code chapter 135B.

“*Late preterm*” means that a newborn infant is born between 34 0/7 and 36 6/7 weeks’ gestation.

“*Levels-of-care assessment tool*” or “*tool*” means a tool to assess the maternal and neonatal risk-appropriate care, using the minimum information necessary to identify a hospital’s maternal level of care based on criteria by the American Congress of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine and a hospital’s neonatal level of care based on criteria by the American Academy of Pediatrics. The tool will be chosen by the department in consultation with the perinatal guidelines advisory committee.

“*Neonate*” means a newborn infant, up to 28 days of life.

“*On-site verification survey*” means an on-site survey conducted by the department’s statewide perinatal care team based at the University of Iowa hospitals and clinics or by a survey team of members (medical experts) contracted to assess a hospital’s ability to meet the level of designation selected by the hospital.

“*Perinatal*” means the five months before and one month after birth.

“*Perinatal center*” means a medical facility capable of providing complex obstetric, fetal and neonatal care.

“*Prenatal*” means during pregnancy.

“*Readily available*” means on site or at a closely related institution by prearranged consultative agreement.

“*Regionalized system of perinatal health care*” means the department’s program for designating regional perinatal health care services at a verified level of care, based on a hospital’s functional capabilities. Levels of care designations are stratified in an increasing order of intensity and complexity for both maternal health care and neonatal health care.

“*Regionalized system of perinatal health care coordinator*” means the department’s program manager for the regionalized system of perinatal health care.

“*Respiratory distress*” means tachypnea (respiratory rate of 60 or more per minute), grunting, tugging, retracting, nasal flaring, or cyanosis. Any or all of these may constitute respiratory distress in a neonate.

“*Reverification*” means the process of periodic review, conducted at least every three years, to certify that a hospital has maintained its designated level of care in accordance with criteria

established under these rules for hospitals that are participating in the regionalized system of perinatal health care.

“Statewide perinatal care program” means a program consisting of the regionalized system of perinatal health care coordinator, the statewide perinatal care team contracted by the department, and the regionalized system of perinatal health care as defined in these rules.

“Statewide perinatal care team” means the educational team based at the University of Iowa hospitals and clinics and contracted by the department to support the regionalized system of perinatal health care and to provide services to decrease perinatal morbidity and mortality.

“Verification” means a process by which the department certifies a hospital’s capacity to provide perinatal care in accordance with criteria established under these rules for hospitals that are participating in the regionalized system of perinatal health care.

641—150.3(135) Duties of statewide perinatal care team. The team will:

1. Promote evidence-based and evidence-informed care of pregnant women and newborns.
2. Provide education and consultation to regional and primary providers of perinatal care.
3. Provide chart review to assess quality of care provided and additional education required.
4. Promote change in practice when needed through sharing best practice ideas, policies and procedures.
5. Promote maternal-fetal transfer if delivery of an at-risk infant or mother is anticipated and a higher level of care is anticipated.
6. Provide on-site verification to determine a hospital’s ability to meet its level-of-care designation.

641—150.4(135) Duties of the department. The department will:

1. Certify a hospital’s capacity to provide perinatal health care in accordance with criteria established under these rules.
2. Provide technical assistance to the hospitals that choose to participate.
3. Review the submitted levels-of-care assessment tool from all participating hospitals.
4. Conduct or coordinate the on-site verification of determined levels of care for maternal and neonatal care hospitals designated as Level I, Level II, Level III and Level IV.

641—150.5(135) Maternal and neonatal levels of care—categorization and verification. Categorization and verification of hospitals participating in Iowa’s regionalized system of perinatal health care will be made by the department based on national recommendations from the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists.

150.5(1) Application for initial verification.

- a. An application for initial verification may be submitted when:
 - (1) A new hospital with a perinatal service is opened;
 - (2) A hospital is reopening after a previously inactive obstetrical unit; or
 - (3) A hospital requests a change to a higher-level designation in maternal care or neonatal care.
- b. A hospital requesting an initial verification may obtain application materials from the department.
- c. Upon receipt of an application from a hospital that is requesting to change to a higher level of maternal or neonatal care, the department will request and review copies of the results of the last site visit to the hospital by the statewide perinatal team or request a site visit. The results of the site visit along with the application will be shared with the statewide perinatal team and any clinical experts appointed by the department to determine if all requirements are met. The recommendations will be sent to the department, which will notify the hospital if its application is approved or denied. If the application is denied, the applicant will be informed of the applicant’s right to appeal the department’s decision.

150.5(2) *Application for a hospital that has previously participated in the regionalized system of perinatal health care.*

a. If a hospital chooses to continue its participation, the hospital must select the levels for maternal care and neonatal care appropriate for the hospital's capacity to provide perinatal health care in accordance with the criteria outlined in these rules.

b. To maintain continuous participation in the regionalized system of perinatal health care, a hospital must complete the levels-of-care assessment tool and an attestation statement. These can be obtained from the department.

c. The department will set dates when each hospital's certification of verification will expire based on the statewide perinatal health care team's site visit schedule and the level of care selected.

150.5(3) *Reverification of level designation.* The levels-of-care assessment tool will be used for all reverifications. The process of reverification of a hospital participating in the regionalized system of perinatal health care will take place once every six years as follows:

a. Reverification of a Level I, Level II or Level III maternal care or neonatal care hospital will be completed through use of the levels-of-care assessment tool and an on-site reverification visit. A hospital must complete and return the levels-of-care assessment tool to the department at least 120 days before the hospital's certification is due to expire. The department will ensure that arrangements are made for the on-site reverification visit. Level II and Level III hospitals may utilize one of two on-site reverification visit options:

- (1) A review conducted by the statewide perinatal care team, or
- (2) A review by an independent out-of-state team identified by the hospital, approved by the department and paid for by the hospital.

b. Reverification of a Level IV maternal care and neonatal care hospital will be completed through the same process as that for a Level I, Level II or Level III maternal care or neonatal care hospital except that the on-site reverification team will consist of an out-of-state team identified by the hospital and approved by the department. The team will include, at a minimum, a maternal-fetal specialist, a neonatologist, an obstetrical nurse and a neonatal nurse. The Level IV hospital will pay the expense of the review team. All department staff and staff contracted by the department involved in the on-site reverification process will sign a confidentiality statement that will be kept on file at the department.

c. Reverification shall not be construed to imply any guarantee on the part of the department as to the level of perinatal health care services available at a hospital.

d. Hospital reverification of the level of care is valid for a period of six years from the effective date unless otherwise specified on the certificate of verification or unless sooner suspended or revoked.

e. As part of the reverification and renewal process, the department or a designated survey team may conduct periodic on-site reviews of the services of the maternal care and neonatal care hospitals, including chart reviews.

150.5(4) *Level designation maintenance, waiver and confidential records.*

a. A hospital that is unable to maintain its designated level of care will notify the department, in writing, within 60 days of the change in capacity to meet the designated level of care.

b. The director may grant a waiver from the requirements of rules adopted under this chapter for any hospital participating in the regionalized system of perinatal health care.

c. Proceedings, records, and reports developed pursuant to this chapter are confidential pursuant to Iowa Code section 135.11(22) and constitute peer review records under Iowa Code section 147.135, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the affected hospital, and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving verification of the participating hospital.

641—150.6(135) Levels of maternal care. The levels of maternal care include basic obstetrical care Level I, specialty care Level II, subspecialty care Level III and regional perinatal health care Level IV.

The levels reflect the overall evidence for risk-appropriate care in a hospital through the availability of appropriate personnel, physical space, equipment, technology, and organization. Each level reflects the minimal capabilities, provider type and functional criteria required.

150.6(1) Level I maternal care hospital.

a. Provider of basic obstetrical care. A Level I maternal care hospital provides care to women who are low risk and are expected to have an uncomplicated birth.

b. Capabilities. A Level I maternal care hospital has the following capabilities:

(1) To perform routine intrapartum and postpartum care that is anticipated to be uncomplicated. Care of uncomplicated pregnancies includes the ability to detect, stabilize and initiate management of unanticipated maternal, fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility that provides specialty maternal care.

(2) To begin an emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care.

c. Types of health care providers. A Level I maternal care hospital will have:

(1) Maternity care providers, including certified nurse-midwives, family practice physicians, or obstetrician-gynecologists, available to attend all births.

(2) Every birth attended by at least two professionals, including the primary maternal care provider and a person competent to provide neonatal resuscitation and postnatal care to stabilize the infant.

(3) Adequate numbers of registered nurses available who have completed orientation and demonstrated competence in the care of obstetric patients, including women and fetuses, consistent with Level I care criteria and who are able to stabilize and transfer high-risk women and newborns.

(4) Nursing leadership with expertise in perinatal nursing care.

(5) A provider with privileges to perform an emergency cesarean delivery, available to attend all deliveries. The provider may be a general surgeon, an obstetrician-gynecologist, or a family practice physician with certification.

(6) A provider of anesthesia services available to provide labor analgesia and surgical anesthesia.

d. Functional criteria of support services. Support services include but are not limited to access to obstetric ultrasonography, laboratory testing, and blood bank supplies at all times. A Level I maternal care hospital will:

(1) Have protocols and capabilities in place for:

1. Massive transfusion,
2. Emergency release of blood products (before full compatibility testing is complete),
3. Management of multiple component therapy.

(2) Ensure optimal care of all pregnant women by having formal transfer plans established in partnership with a higher-level receiving hospital. These plans will include:

1. Risk identification,
2. Determination of conditions necessitating consultation,
3. Referral and transfer, and
4. A reliable, accurate, and comprehensive communication system between the participating hospital and the transport team.

(3) Have education and quality improvement programs to maximize patient safety, provide such programs through collaboration with facilities with higher levels of care that receive transfers, or both.

(4) Have data collection, storage and retrieval to support quality improvement.

150.6(2) Level II maternal care hospital.

a. Provider of specialty care. In addition to meeting the criteria of a Level I maternal care hospital, a Level II maternal care hospital provides care of appropriate high-risk pregnant women, both those directly admitted to the hospital and those transferred from another hospital.

b. Capabilities. In addition to having the capabilities of a Level I maternal care hospital, a Level II maternal care hospital has the following capabilities:

(1) The infrastructure for continuous availability of adequate numbers of registered nurses who have demonstrated competence in the care of obstetric patients (women and fetuses).

(2) Orientation and demonstrated competence consistent with Level II care criteria and the capability to stabilize and transfer high-risk women and newborns who exceed Level II care criteria.

c. Types of health care providers. In addition to meeting the health care provider requirements of a Level I maternal care hospital, a Level II maternal care hospital will have:

(1) Health care providers, including certified nurse-midwives or family physicians.

(2) Nursing leaders and staff with formal training and experience in the provision of perinatal nursing care who can coordinate with respective neonatal care services.

(3) An attending obstetrician-gynecologist available at all times.

(4) A board-certified or board-eligible obstetrician-gynecologist with special interest and experience in obstetric care as the director of obstetric services.

(5) Access to a maternal-fetal medicine subspecialist for consultation, available on site, by telephone, or by telemedicine as needed.

(6) A provider of anesthesia services available at all times to provide labor analgesia and surgical anesthesia.

(7) A board-certified or board-eligible anesthesiologist with special training or experience in obstetric anesthesia, available for consultation.

(8) Medical and surgical consultants available to stabilize obstetric patients who have been directly admitted to the facility or transferred from other hospitals.

d. Functional criteria of support services. In addition to meeting the support services requirements of a Level I maternal care hospital, a Level II maternal care hospital will have:

(1) Computed tomography scan and, ideally, magnetic resonance imaging with interpretation available.

(2) Basic ultrasonographic imaging services for maternal and fetal assessment at all times, either in house or on call.

(3) Special equipment needed to accommodate the care and services needed for obese women. In addition, based on the patient's BMI and other risk factors, a consultation with an obstetrician-gynecologist or a maternal fetal medicine specialist should be considered.

(4) The ability to provide high-risk obstetrical care, but efforts should be made to transfer women whose newborns are likely to need a higher level of care than a Level II maternal care hospital can provide, or when the pregnancy has risk factors that require the consultation or care of a maternal-fetal medicine specialist.

150.6(3) Level III maternal care hospital.

a. Provider of subspecialty care. A Level III maternal care hospital provides care to women that includes all Level I and Level II services and has subspecialists available on site, by telephone, or by telemedicine to assist in providing care for more complex maternal and fetal conditions.

b. Capabilities. A Level III maternal care hospital functions as the regional perinatal health care center for some areas of Iowa if there are no Level IV maternal care hospitals available. In these areas, a Level III maternal care hospital will be responsible for the leadership; facilitation of transport and referral; educational outreach; and data collection, storage and retrieval to support quality improvement. Designation of Level III maternal care hospital should be based on the demonstrated experience and capability of the facility to provide comprehensive management of severe maternal and fetal complications.

c. Types of health care providers. In addition to meeting the health care provider requirements of a Level II maternal care hospital, a Level III maternal care hospital will have:

(1) An obstetrician-gynecologist with inpatient privileges, available on site at all times.

(2) A maternal-fetal medicine subspecialist with inpatient privileges, available at all times, either on site, by telephone, or by telemedicine.

(3) A director of the maternal-fetal medicine service who is a board-certified or board-eligible maternal-fetal medicine subspecialist.

(4) A board-certified or board-eligible obstetrician-gynecologist with special interest and experience in obstetric care directing obstetric services.

(5) A provider of anesthesia services available at all times on site.

(6) A board-certified or board-eligible anesthesiologist with special training or experience in obstetric anesthesia who is in charge of obstetric anesthesia services.

(7) A full complement of subspecialists, available for inpatient consultations, including subspecialists in:

1. Critical care,
2. General surgery,
3. Infectious disease,
4. Hematology,
5. Cardiology,
6. Nephrology,
7. Neurology, and
8. Neonatology.

(8) Nursing leaders and adequate numbers of registered nurses who have completed orientation and demonstrated competence in the care of obstetric patients (women and fetuses) consistent with Level III care criteria, including the transfer of high-risk women who exceed Level III care criteria, and who have special training and experience in the management of women with complex maternal illnesses and obstetric complications. Nursing personnel will be continuously available.

d. Functional criteria of support services. In addition to meeting the support services requirements of a Level II maternal care hospital, a Level III maternal care hospital will have:

- (1) An on-site intensive care unit to accept pregnant women.
- (2) Critical care providers on site to actively collaborate with maternal-fetal specialists at all times.
- (3) Equipment and personnel with expertise available on site to ventilate and monitor women in the labor and delivery unit until they can be safely transferred to the intensive care unit.

(4) The ability to provide the following imaging services, with interpretation available at all times:

1. Basic interventional radiology,
2. Maternal echocardiography,
3. Computed tomography,
4. Magnetic resonance imaging, and
5. Nuclear medicine imaging.

(5) The ability to perform detailed obstetric ultrasonography and fetal assessment, including Doppler studies.

150.6(4) Level IV maternal care hospital.

a. Provider of services as a regional perinatal health care center. In addition to meeting the requirements for a Level III maternal care hospital, a Level IV maternal care hospital provides care to women with additional requirements and has considerable experience in the care of the most complex and critically ill pregnant women throughout antepartum, intrapartum, and postpartum care. The particular specialty of fetal surgery, advanced neurosurgery, transplant, and advanced cardiovascular capabilities may not all be available at an individual Level IV maternal care hospital. In some cases, specific advanced care will require care coordination to the Level IV maternal care hospital by availability of specific expertise, including but not limited to fetal surgery, advanced neurosurgery, transplant, and advanced cardiovascular capabilities. Each hospital will have a clear understanding of the categories of perinatal patients who can be managed appropriately in the local hospital and those who must be transferred.

b. Capabilities. Although Level III and Level IV maternal care hospitals may seem to overlap, a Level IV maternal care hospital is distinct from a Level III maternal care hospital in the approach to the care of pregnant women and women in the postpartum period with complex and critical illnesses.

In addition to having an intensive care unit on site for obstetric patients, a Level IV maternal care hospital must have evidence of a maternal-fetal medicine care team that has the expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. The maternal-fetal medicine team collaborates actively in the co-management of all obstetric patients who require critical care and intensive care unit services, including co-management of intensive care unit-admitted obstetric patients.

c. Types of health care providers. In addition to meeting the health care provider requirements of a Level III maternal care hospital, a Level IV maternal care hospital will have:

(1) A maternal-fetal medicine team member with full privileges, available at all times for on-site consultation and management.

(2) A board-certified maternal-fetal medicine subspecialist with expertise in critical care obstetrics to lead the team.

(3) A maternal-fetal medicine team with expertise in critical care at the physician level, nursing level, and ancillary services level.

(4) Institutional support for the routine involvement of a maternal-fetal medicine care team with the critical care units and specialists. A key principle of caring for critically ill pregnant and peripartum women is the hospital's recognition of the need for seamless communication between maternal-fetal medicine subspecialists and other subspecialists in the planning and facilitation of care for women with the most high-risk complications of pregnancy.

(5) A commitment to having physician and nursing leaders with expertise in maternal intensive and critical care, as well as adequate numbers of available registered nurses in a Level IV maternal care hospital who have experience in the care of women with complex medical illnesses and obstetric complications; this experience includes completed orientation and demonstrated competence in the care of obstetric patients (women and fetuses) consistent with Level IV maternal care criteria.

(6) A director of obstetric services who is a board-certified maternal-fetal medicine subspecialist or a board-certified obstetrician-gynecologist with expertise in critical care obstetrics.

(7) A provider of anesthesia services available on site at all times.

(8) A board-certified anesthesiologist with special training or experience in obstetric anesthesia who is in charge of obstetric anesthesia services.

(9) Adult medical and surgical specialty and subspecialty consultants, a minimum of those listed for a Level III maternal care hospital, available on site at all times to collaborate with the maternal-fetal medicine care team.

d. Functional criteria of support services. In addition to meeting the support services requirements of a Level III maternal care hospital, a Level IV maternal care hospital will have:

(1) The capability for on-site medical and surgical care of complex maternal conditions (e.g., congenital maternal cardiac lesions, vascular injuries, neurosurgical emergencies, and transplants) with the availability of critical (or intensive) care unit beds.

(2) Perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region and analysis and evaluation of regional data, including perinatal complications, outcomes and quality improvement.

641—150.7(135) Maternal-fetal transport—all levels. Maternal-fetal transport is an essential component of perinatal care. A hospital participating in the regionalized system of perinatal health care must be familiar with its own resources and capabilities in dealing with obstetrical and neonatal complications. In most instances, maternal-fetal transport is preferable to neonatal transport. Each hospital, when transporting or accepting a transport, needs a system in place to facilitate a smooth transition of care in the most expeditious manner possible. The majority of maternal-fetal transports can be carried out by ground transportation. It is important for ambulance services to be equipped for maternal-fetal transport and have appropriately trained staff.

641—150.8(135) Levels of neonatal care. The levels of neonatal care include basic neonatal care Level I, specialty care Level II, and subspecialty intensive care Level III and Level IV. The levels reflect the overall evidence for risk-appropriate care through the availability of appropriate functional criteria, physical facilities, medical and nursing personnel, outreach education, allied health personnel and services, infection control, newborn or neonatal safety, neonatal transport and quality improvement.

150.8(1) Level I neonatal care hospital.

a. Provider of basic neonatal care. A Level I neonatal care hospital provides a basic level of care to neonates without complications. A Level I neonatal care hospital has the following capabilities:

- (1) To provide neonatal resuscitation at every delivery.
- (2) To evaluate and provide postnatal care to stable term newborn infants.
- (3) To stabilize and provide care for infants born at 35 to 37 weeks' gestation who remain physiologically stable.
- (4) To stabilize newborn infants who are ill and those born at less than 35 weeks' gestation until transfer to a higher level of care.
- (5) To provide leadership in early risk identification before and after birth.
- (6) To seek consultation or referral for high-risk neonates.
- (7) To provide public and professional education.

b. Functions. A Level I neonatal care hospital has a family-centered philosophy. Parents have reasonable access to their newborns 24 hours a day within all functional units and are encouraged to participate in the care of their newborns. Generally, a newborn can be with its parents in the mother's room.

c. Physical facilities. A Level I neonatal care hospital will maintain a nursery for normal-term or late preterm neonates.

d. Medical personnel. At a Level I neonatal care hospital, neonatal care is under the supervision of one of the following:

- (1) A board-eligible or board-certified neonatologist,
- (2) A pediatrician,
- (3) A family medicine physician,
- (4) A board-eligible or board-certified advanced registered nurse practitioner, or
- (5) A physician assistant.

e. Nursing personnel. At a Level I neonatal care hospital, a registered nurse assigned to the neonatal service has nursing orientation to and demonstrates competency in the care of a neonate.

f. Outreach education. A Level I neonatal care hospital will assume an active role in the development and coordination of wellness and preventive programs concerning neonatal and child health at the community level, including parenting, breastfeeding, and cessation of smoking.

g. Allied health personnel and services. A Level I neonatal care hospital will have available, at a minimum, the following allied health personnel and services:

- (1) Dietitian with knowledge of maternal and neonatal nutrition management,
- (2) Social worker,
- (3) Bioengineer-safety and environmental control,
- (4) Pharmacy,
- (5) Radiology,
- (6) Laboratory,
- (7) Pathology, and
- (8) Chaplain, spiritual support.

h. Infection control.

(1) Each Level I neonatal care hospital will establish written policies and procedures for assessing the health of personnel assigned to the perinatal care services and of those who have significant contact with the newborn. The policies and procedures will include restricting contact with

patients when necessary and screening per department recommendations for health care providers. Routine culturing of specimens obtained from personnel is not useful, although selective culturing may be of value when a pattern of infection is suspected.

(2) No special or separate isolation facility is required for neonates born at home or in transit to the hospital. Detailed descriptions of the isolation categories and requirements will be available in each hospital's infection control manual.

i. Newborn safety. At a Level I neonatal care hospital, the protection of newborns is the responsibility of all personnel in the neonatal care hospital. Newborns will always be within the sight and supervision of hospital staff, the mother, or other family members or friends designated by the mother. Each neonatal care hospital has a policy established that addresses strategies to promote newborn safety.

150.8(2) *Level II neonatal care hospital.*

a. Provider of specialty care. In addition to meeting the requirements for care and services as a Level I neonatal care hospital, a Level II neonatal care hospital will:

- (1) Provide management of certain high-risk neonates with selected complications.
- (2) Have a board-certified or board-eligible neonatologist(s) or a board-certified or board-eligible pediatrician(s) on staff, one of whom directs the special care nursery.

b. Functions. In addition to performing the functions of a Level I neonatal care hospital, a Level II neonatal care hospital will have the capability to:

(1) At a minimum, manage neonates of greater than or equal to 32 weeks' gestation and weighing greater than or equal to 1,500 grams who have physiological immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis and, for neonates of 32 weeks' gestation and weighing less than 1,500 grams, recommend consultation with a higher-level facility by prearranged consultative agreement.

(2) Provide mechanical ventilation for a brief duration (less than 24 hours).

(3) Provide continuous positive airway pressure as needed (less than 24 hours).

(4) Stabilize infants born before 32 weeks and weighing less than 1,500 grams until transfer to a Level III or Level IV neonatal care hospital.

(5) Provide care for infants convalescing after intensive care.

c. Physical facilities. In addition to having the physical facilities of a Level I neonatal care hospital, a Level II neonatal care hospital will have:

(1) A special care nursery (a special area designated for the care of sick neonates),

(2) A mechanical ventilator,

(3) A portable X-ray machine,

(4) A laboratory with a blood gas analyzer,

(5) Physiologic monitoring equipment, and

(6) A pharmacy.

d. Medical personnel. In addition to having the medical personnel of a Level I neonatal care hospital, a Level II neonatal care hospital will:

(1) Be under the co-direction/supervision of a board-eligible or board-certified neonatologist or pediatrician.

(2) Have a neonatologist or pediatrician on staff. Other provider types that may be utilized include a pediatric hospitalist, a neonatal nurse practitioner or pediatric nurse practitioner or a physician assistant with appropriate training.

(3) Have allied medical specialists in various disciplines on staff, including specialists in internal medicine, radiology, and pathology.

e. Nursing personnel. In addition to having the nursing personnel of a Level I neonatal care hospital, a Level II neonatal care hospital has nursing orientation to and demonstrates competency in the care of sick neonates.

f. Outreach education. A Level II neonatal care hospital has the same responsibility for outreach education as that of a Level I neonatal care hospital.

g. Allied health personnel and services. In addition to having the allied health personnel and services of a Level I neonatal care hospital, a Level II neonatal care hospital has:

- (1) Respiratory therapists,
- (2) Certified laboratory technicians/blood gas technicians, and
- (3) X-ray technologists and ultrasound technicians with neonatal/perinatal experience.

h. Infection control. A Level II neonatal care hospital has the same infection control guidelines as those for a Level I neonatal care hospital.

i. Neonatal safety. A Level II neonatal care hospital has the same requirements for newborn safety as those for a Level I neonatal care hospital.

j. Neonatal transport. In addition to having the Level I neonatal care hospital capabilities for neonatal transport, a Level II neonatal care hospital is expected to accept patient referrals when appropriate. A critical function of providers at a Level II neonatal care hospital is to communicate with the providers at a Level I neonatal care hospital in deciding whether a particular patient should be transported to the Level II neonatal care hospital. Careful assessment of the hospital's capabilities for perinatal management will be critical in these decisions. This information will need to be disseminated among the hospital staff. Providers of obstetric care need to know the critical gestational age limitations for their particular nursery. Below this gestational age, maternal-fetal transport should be utilized if delivery is anticipated and the circumstances permit.

k. Perinatal care committee.

(1) A Level II neonatal care hospital must maintain a perinatal care committee. Members of this committee will represent, at a minimum, the fields of:

1. Obstetrics,
2. Pediatrics,
3. Family practice,
4. Nursing,
5. Administration,
6. Laboratory,
7. Respiratory therapy,
8. Anesthesia, and
9. Social services.

(2) Responsibilities of the perinatal care committee include the following:

1. To develop policies for the unit, including provisions to ensure adequate patient care by qualified providers.

2. To conduct a meeting, at least semiannually, to resolve problems related to the unit.

3. To review educational activities conducted by the unit.

4. To serve as a general liaison between the various groups represented on the committee.

150.8(3) Level III neonatal care hospital.

a. Provider of subspecialty intensive care. In addition to providing the care and services of a Level II neonatal care hospital, a Level III neonatal care hospital will manage high-risk neonates, including infants born at less than 32 weeks or weighing less than 1,500 grams. High-risk neonates requiring surgical intervention or pediatric subspecialty should go to a Level IV neonatal care hospital.

b. Functions. In addition to performing the functions of a Level II neonatal care hospital, a Level III neonatal care hospital will have the capability to:

- (1) Provide sustained life support.
- (2) Provide comprehensive care for infants born at less than 32 weeks and weighing less than 1,500 grams and infants born at all gestations and birth weights who have critical illness.
- (3) Provide an organized program for monitoring treatment and follow-up of retinopathy of prematurity.

(4) Maintain a prearranged consultative agreement with a higher-level hospital within the Level III neonatal care hospital's referral area.

(5) Transfer a surgical patient within approximately two hours from the time the referral call is made until arrival at the referral hospital.

(6) Provide follow-up care for high-risk newborns.

c. Physical facilities. In addition to having the physical facilities of a Level II neonatal care hospital, a Level III neonatal care hospital:

(1) Has a neonatal intensive care unit with continuously available personnel, including a neonatologist, neonatal nurses and respiratory therapists to provide life support for as long as necessary.

(2) Provides a full range of respiratory support that includes invasive mechanical ventilation and may include high-frequency ventilation or inhaled nitric oxide or both.

(3) Performs advanced imaging, with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography.

(4) Maintains a neonatal transport team for the regional area served.

d. Medical personnel. In addition to having the medical personnel of a Level II neonatal care hospital, a Level III neonatal care hospital will:

(1) Have a medical director of the neonatal intensive care unit who is a full-time, board-eligible or board-certified neonatologist.

(2) Provide prompt and readily available access to the following, either on site or by prearranged consultative agreement. Using telemedicine technology or telephone consultation, a prearranged consultation can be performed from a distant location by:

1. Pediatric medical subspecialists,
2. A pediatric surgical specialist,
3. A pediatric anesthesiologist, and
4. A pediatric ophthalmologist.

(3) Have a neonatologist on the premises when an unstable critically ill infant is in the Level III neonatal care hospital.

e. Nursing personnel. A Level III neonatal care hospital has the same requirements for nursing personnel as those of a Level II neonatal care hospital.

f. Outreach education. Outreach education is provided to each hospital in the referral area at least once per year. This outreach education can be achieved by one or more of the following:

- (1) Sponsoring an annual conference.
- (2) Visiting a Level I neonatal care hospital and a Level II neonatal care hospital.
- (3) Providing educational programs and materials for the staff members of the Level I and Level II neonatal care hospitals.

g. Allied health personnel and services. In addition to having the allied health personnel and services of a Level II neonatal care hospital, a Level III neonatal care hospital has:

(1) X-ray technologists and ultrasound technicians with neonatal/perinatal experience, available on a 24-hour basis.

(2) Social work services with social workers assigned specifically to the neonatal units.

h. Infection control. A Level III neonatal care hospital has the same infection control guidelines as those of a Level I neonatal care hospital.

i. Neonatal safety. A Level III neonatal care hospital has the same requirements for newborn safety as those for a Level I neonatal care hospital.

j. Neonatal transport. In addition to having the Level II neonatal care hospital transport capabilities, a Level III neonatal care hospital is capable of providing neonatal transport with crews who have demonstrated competence in neonatal resuscitation and stabilization. Important decisions to be made jointly will include:

- (1) The appropriateness of transport.
- (2) The best mode of transportation.

- (3) The need for additional personnel accompanying the transport.
- (4) The appropriate medical management to initiate prior to transport.

k. *Perinatal care committee.* A Level III neonatal care hospital shall maintain a perinatal care committee that meets the same criteria as those for a Level II neonatal care hospital.

150.8(4) Level IV neonatal care hospital.

a. *Provider of subspecialty intensive care.* In addition to providing the level-of-care services of a Level III neonatal care hospital, a Level IV neonatal care hospital manages higher-risk neonates. The differentiating factor between a Level III neonatal care hospital and a Level IV neonatal care hospital is primarily one of having additional professional staff with considerable experience in the care of the most complex and critically ill infants and having the ability to provide surgical repair of complex congenital or acquired conditions.

b. *Physical facilities.* In addition to having the physical facilities of a Level III neonatal care hospital, a Level IV neonatal care hospital has more equipment, more extensive physical facilities and will serve a more complicated patient population.

c. *Medical personnel.* In addition to having the medical personnel of a Level III neonatal care hospital, a Level IV neonatal care hospital will:

- (1) Have a medical director of the neonatal intensive care unit who is a full-time, board-certified neonatologist.
- (2) Have anesthesia providers on staff with special training or experience in pediatric anesthesia.
- (3) Maintain a full range of pediatric medical subspecialists and pediatric surgical subspecialists at the site.
- (4) Have the subspecialist physicians immediately available to the Level IV neonatal care hospital.
- (5) Have a neonatologist on the premises when an unstable critically ill infant is in the Level IV neonatal care hospital.

d. *Nursing personnel.* A Level IV neonatal care hospital has the same requirements for nursing personnel as those for a Level II neonatal care hospital.

e. *Outreach education.* A Level IV neonatal care hospital has the same responsibilities for outreach education as those for a Level III neonatal care hospital.

f. *Allied health personnel and services.* A Level IV neonatal care hospital has the same level of allied health personnel and services as that of a Level III neonatal care hospital.

g. *Infection control.* A Level IV neonatal care hospital has the same infection control guidelines as those for a Level I neonatal care hospital.

h. *Neonatal safety.* A Level IV neonatal care hospital has the same requirements for neonatal safety as those for a Level I neonatal care hospital.

i. *Neonatal transport.* In addition to meeting the neonatal transport requirements of a Level III neonatal care hospital, a Level IV neonatal care hospital is capable of providing ground and air transportation with crews who have demonstrated competencies in neonatal resuscitation and stabilization.

j. *Perinatal care committee.* In addition to maintaining a perinatal care committee that meets the same criteria as those for a Level II neonatal care hospital, a Level IV neonatal care hospital maintains a perinatal care committee that has additional representation by surgical specialties. The Level IV neonatal care hospital's perinatal care committee will maintain and analyze data on long-term outcomes to evaluate the effectiveness of the delivery of perinatal health care services.

641—150.9(135) Grant or denial of certificate of verification; and offenses and penalties.

150.9(1) Upon receipt of the levels-of-care assessment tool and the on-site survey results, if required, the department will within 90 days issue its decision to grant or deny the hospital a certificate of verification. The department may deny verification or may give a citation and warning, place on probation, suspend, or revoke existing verification if the department finds reason to believe the hospital's perinatal care program has not been or will not be operated in compliance with these

rules. The denial, citation and warning, period of probation, suspension or revocation will be effected and may be appealed in accordance with the requirements of Iowa Code section 17A.12.

150.9(2) All complaints regarding the operation of a participating hospital's perinatal care program shall be reported to the department and to the department of inspections, appeals, and licensing.

150.9(3) Complaints and the investigative process will be treated as confidential to the extent they are protected by Iowa Code sections 22.7 and 135.11(27).

150.9(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

150.9(5) Notice of denial, citation and warning, probation, suspension or revocation will be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the hospital of denial, citation and warning, probation, suspension or revocation will be served by certified mail, return receipt requested, or by personal service.

150.9(6) Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation must be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice to take action. If the request is made within the 20-day time period, the notice to take action will be deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation will become the department's final agency action.

150.9(7) Upon receipt of a request for hearing, the request will be forwarded within five working days to the department of inspections, appeals, and licensing pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information, which may be provided by the aggrieved party, shall also be provided to the department of inspections, appeals, and licensing.

150.9(8) The hearing shall be conducted according to the procedural rules of the department of inspections, appeals, and licensing found in 481—Chapter 10.

150.9(9) When the administrative law judge makes a proposed decision and order, it will be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

150.9(10) Any appeal to the director for review of the proposed decision and order of the administrative law judge must be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal will also be mailed to the administrative law judge. Any request for an appeal must state the reason for appeal.

150.9(11) Upon receipt of an appeal request, the administrative law judge will prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions, and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings on them.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

150.9(12) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and will be delivered by certified mail, return receipt requested, or by personal service.

150.9(13) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

150.9(14) Any petition for judicial review of a decision and order must be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal will be sent to the department by certified mail, return receipt requested, or by personal service.

150.9(15) The party that appeals a final agency action to the district court must pay the cost of the preparation of a transcript of the contested case hearing for the district court.

150.9(16) Final decisions of the department relating to disciplinary proceedings may be transmitted to the department of inspections, appeals, and licensing and to the appropriate professional associations or news media.

641—150.10(135) Prohibited acts. A hospital that imparts or conveys, or causes to be imparted or conveyed, that it is a participating hospital in Iowa's regionalized system of perinatal health care, or that uses any other term, such as a designated level of care, to indicate or imply that the hospital is a participating hospital in the regionalized system of perinatal health care without having obtained a certificate of verification from the department is subject to licensure disciplinary action by the department of inspections, appeals, and licensing, as well as to the application by the director to the district court for a writ of injunction to restrain the use of the term or terms "Level I maternal care or neonatal care hospital," "Level II maternal care or neonatal care hospital," "Level III maternal care or neonatal care hospital" and "Level IV maternal care or neonatal care hospital" in relation to the provision of perinatal health care services.

641—150.11(135) Construction of rules. Nothing in these administrative rules shall be construed to restrict a hospital from providing any services for which it is duly authorized.

These rules are intended to implement Iowa Code section 135.11.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 157
“Standards for Substance Abuse Treatment and Assessment
and the Operating a Motor Vehicle While Intoxicated (OWI) Law”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 125.7(4)

State or federal law(s) implemented by the rulemaking: Iowa Code chapters 125 and 321J

Public Hearing

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

November 6, 2024
10 a.m.

Microsoft Teams
Meeting ID: 268 876 122 100
Passcode: QXqezE

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:

Victoria L. Daniels
Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

The purpose of this proposed rulemaking is to ensure that a person charged with an operating while intoxicated (OWI) offense completes a drinking drivers course and undergoes a substance abuse evaluation and/or treatment conducted by a regulated, licensed substance use disorder treatment program.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No classes of persons will bear the costs.
 - Classes of persons that will benefit from the proposed rulemaking:
Individuals who must receive court-ordered screening, evaluation, and treatment services due to receiving an OWI offense will benefit from the proposed rulemaking.
2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:
 - Quantitative description of impact:
There are approximately 100 licensed programs in Iowa that provide screening, evaluation, treatment, and drinking drivers courses to individuals charged with an OWI.
 - Qualitative description of impact:

Licensed programs are regulated for adherence with the American Society of Addiction Medicine (ASAM) Criteria, which is the most widely used and comprehensive set of standards for placement, continued service, and transfer of patients with addiction and co-occurring disorders.

3. Costs to the State:

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

Administrative costs will be borne by the Department.

- Anticipated effect on state revenues:

There are no anticipated effects on state revenues.

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

Without these rules, persons charged with an OWI offense may seek substance use disorder assessment and/or treatment services with providers who are not regulated. Licensed programs are regulated for adherence with the ASAM Criteria. Unregulated providers may not have the expertise, knowledge, or competency to assess and/or treat substance use disorders. Without this regulation and oversight, there is an increased risk for providers to utilize treatment techniques that endanger the health, safety, and/or welfare of a patient, potential patient, concerned person, or member of the public.

In addition, without these rules, sole proprietors and other small business entities that are issued OWI evaluation-only licenses may be negatively impacted. Removal of this chapter may create an influx of service providers, which could reduce the volume of clients for already licensed small businesses.

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

There are no less costly methods or less intrusive methods.

6. Alternative methods considered by the agency:

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

There were no alternative methods that were seriously considered.

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

Please refer to the above benefits enumerated.

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?

Rulemaking will have no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 641—Chapter 157 and adopt the following **new** chapter in lieu thereof:

CHAPTER 157

STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND ASSESSMENT PROGRAMS AND THE OPERATING A MOTOR VEHICLE WHILE INTOXICATED (OWI) LAW

641—157.1(125) Definitions. Unless otherwise indicated, the following definitions apply to the specific terms used in these rules:

“Assessment” means the ongoing process of identifying a diagnosis, ruling out other diagnoses, and determining the level of care needed by the client.

“Course for drinking drivers” means an approved course designed to inform the offender about drinking and driving and to encourage the offender to assess the offender’s own drinking and driving behavior in order to select practical alternatives. Enrollment in the course is not limited to persons ordered to enroll, attend, and successfully complete the course required under Iowa Code sections 321J.1 and 321J.17. However, any person under the age of 18 who is required to attend the course for violation of Iowa Code section 321J.2 or 321J.17 must attend a course offered by a substance abuse treatment program licensed under Iowa Code chapter 125. Any instructional course for drinking drivers shall be approved by the department of education in consultation with the community colleges and substance abuse treatment programs licensed under Iowa Code chapter 125 and using the course of instruction detailed in rule 281—21.31(321J).

“Evaluation” means the process to evaluate the client’s strengths, weaknesses, problems, and needs for the purpose of defining a course of treatment. This includes use of a standardized placement screening and any additional patient/client profile information, and recommendation to an appropriate level of care.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996.

“Licensed” means issuance of a license by the department, which validates the licensee’s compliance with substance use disorder treatment program standards and authorizes the licensee to operate a substance use disorder treatment program in the state of Iowa.

“Posttreatment” means continuing care after primary treatment has been completed.

“Primary treatment” means substance use disorder treatment modality, including licensed program services under 641—Chapter 155.

“Program” means any individual, partnership, corporation, association, governmental subdivision or public or private organization.

“Qualifying program” means a program which has a contract with the state of Iowa or the state’s contracted managed care entity to provide substance abuse treatment using a sliding fee scale.

“Satisfactory completion of the drinking drivers course” means receiving at the completion of the course a grade from the course instructor of “C” or “2.0,” or better.

“Screening” means the process by which a client/patient is determined at risk and in need of further evaluation. The focus is on the minimum criteria necessary for appropriateness/eligibility.

“Treatment” means the broad range of planned and continuing, inpatient, outpatient, and residential care services, including diagnostic evaluation, counseling, medical, psychiatric, psychological, and social service care, which may be extended to concerned persons, concerned family members, or significant others, and which is geared toward influencing the behavior of such individuals to achieve a state of rehabilitation.

641—157.2(125) Screening, evaluation, treatment, and drinking drivers course. Persons who are charged with operating a motor vehicle while intoxicated (OWI), Iowa Code section 321J.2, and whose driver’s license or nonresident operating privileges are revoked under Iowa Code chapter 321J shall be assigned to undergo a substance abuse evaluation and, if recommended, treatment from a provider licensed by the department under Iowa Code chapter 125.

157.2(1) *Screening.* The initial screening shall consist of a generally accepted standardized substance abuse screening instrument. The program shall utilize a recognized diagnostic test or tool to determine a “substance use disorder” as those terms are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein). In addition, programs shall collect information on blood alcohol content at time of arrest, history of other alcohol or drug-related arrests, history of alcohol/drug treatment, history of mental health problems and treatment, any OWI arrest that included personal injury or additional charge(s), and family history of substance abuse.

157.2(2) *Evaluation.* In accordance with the American Society of Addiction Medicine (ASAM) Criteria and accepted standards of practice, the evaluation shall consist of evaluating a person’s strengths, resources, preferences, limitations, problems and needs; determining the licensed program services needed by the patient; determining the patient’s eligibility for program services; and identifying treatment plan priorities.

157.2(3) *Treatment.* Treatment shall consist of a broad range of planned and continuing, inpatient, outpatient, and residential care services, including ongoing diagnostic evaluation, counseling, and medical, psychiatric, psychological, and social service care geared toward influencing the behavior of such individuals to achieve a state of rehabilitation. Individuals will be placed in the appropriate level of care at a substance use disorder treatment program licensed by the department under Iowa Code chapter 125 in accordance with the most current edition of the ASAM Criteria.

157.2(4) *Drinking drivers course.* Substance abuse treatment programs licensed by the department under Iowa Code chapter 125 may provide the drinking drivers course if the course curriculum is approved by the department of education under Iowa Code section 321J.22 and rule 281—21.31(321J).

641—157.3(125) Screening, evaluation, treatment, and drinking drivers course completion. The program shall report substance use disorder screening, assessment, evaluation and treatment completion to the department of transportation and to the district court in accordance with Iowa Code sections 125.37, 125.84 and 125.86; the federal confidentiality regulations, “Confidentiality of Alcohol and Drug Abuse Patient Records,” 42 CFR Part 2, effective June 9, 1987; HIPAA (1996); and other relevant provisions of federal and state law. The program shall report satisfactory completion of the drinking drivers course to the department of education in accordance with Iowa Code section 321J.22 and rule 281—21.31(260C); the federal confidentiality regulations, “Confidentiality of Alcohol and Drug Abuse Patient Records,” 42 CFR Part 2, effective June 9, 1987; HIPAA (1996); and other relevant provisions of federal and state law.

157.3(1) *Reporting form.* Programs shall report screening, evaluation, and treatment completion utilizing the form “Notice Iowa Code 321J—Confidential Medical Record.” Iowa substance abuse evaluation and treatment providers licensed by the department under Iowa Code chapter 125 shall submit this form online to the department of transportation using the department of transportation’s website.

157.3(2) *Primary treatment.* Upon completion of primary treatment, programs shall report to the department of transportation and the courts that treatment has been completed in accordance with Iowa Code section 321J.22; the federal confidentiality regulations, “Confidentiality of Alcohol and Drug Abuse Patient Records,” 42 CFR Part 2, effective June 9, 1987; HIPAA (1996); and other relevant provisions of federal and state law.

157.3(3) *Posttreatment results.* If the court orders a posttreatment program, the program shall report progress and attendance to the person’s probation officer or otherwise as ordered by the court in accordance with Iowa Code section 321J.22; the federal confidentiality regulations, “Confidentiality of Alcohol and Drug Abuse Patient Records,” 42 CFR Part 2, effective June 9, 1987; HIPAA (1996); and other relevant provisions of federal and state law.

157.3(4) *Drinking drivers course.* Substance abuse treatment programs licensed by the department under Iowa Code chapter 125 may provide the drinking drivers course and shall report satisfactory completion of the drinking drivers course to the department of education in accordance with Iowa Code section 321J.22 and rule 281—21.31(260C).

641—157.4(125) Cost of evaluation and treatment.

157.4(1) *Screening and evaluation.* The program shall charge no more than \$125 for the cost of screening and evaluation. The individual or the individual's insurance provider shall be responsible for the costs of the screening and evaluation.

157.4(2) *Treatment.* Qualifying programs shall consider a person admitted to the program pursuant to Iowa Code section 321J.3 who does not possess sufficient income or estate to make payment of the costs of the treatment in whole or in part to be a state patient and eligible for state-funded treatment as provided in Iowa Code section 125.44. Qualifying programs shall utilize a sliding fee schedule approved by the department to determine cost of treatment. There is no prohibition on any individual from paying in whole the cost of treatment.

157.4(3) *Reimbursement.* Programs shall be able to seek reimbursement of the cost of screening, evaluation and treatment from an individual's insurance company, firm or corporation bound to pay, or from Medicaid for an individual who is eligible or enrolled in Medicaid.

641—157.5(125) Timeliness. The program shall conduct and complete substance abuse evaluations and treatment at the program's earliest convenience.

641—157.6(125) Confidentiality. Programs will abide by the standards for patient records set forth in rule 641—155.21(125,135).

641—157.7(125) Records. Programs shall maintain records in accordance with 641—subrule 155.21(10).

641—157.8(125) Reciprocity. For a resident of a state other than Iowa or an Iowa resident obtaining evaluation or treatment outside the state, screening, evaluation or treatment services shall be provided by programs licensed or approved by that state's substance abuse authority. Programs shall submit the results of the screening, evaluation and treatment to the department for review and reporting purposes to the department of transportation.

These rules are intended to implement Iowa Code section 125.13.

Regulatory Analysis

Notice of Intended Action to be published: 641—Chapter 158
“Regions for Substance Abuse Prevention and Treatment”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 125.7

State or federal law(s) implemented by the rulemaking: Iowa Code section 125.12

Public Hearing

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

November 7, 2024
2 p.m.

Microsoft Teams
Meeting ID: 233 331 347 558
Passcode: h2yRwX

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:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed rulemaking rescinds Chapter 158.

Analysis of Impact

1. Persons affected by the proposed rulemaking:
 - Classes of persons that will bear the costs of the proposed rulemaking:
No costs are associated with this rulemaking.
 - Classes of persons that will benefit from the proposed rulemaking:
None; however, neither will any be harmed.
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:
Nine administrative rules will be rescinded.
 - Qualitative description of impact:
The Iowa Code section that provides rulemaking authority will be repealed effective July 1, 2025, under the Governor’s Behavioral Health Bill, 2024 Iowa Acts, House File 2673.
3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
There will be no implementation and enforcement costs borne by the Department.
 - Anticipated effect on state revenues:
There is no anticipated effect on state revenues.

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

Not applicable.

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

No, rulemaking authority will go away with the passage of 2024 Iowa Acts, House File 2673, in which the pertinent provision is effective July 1, 2025.

6. Alternative methods considered by the agency:

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

There were no alternative methods that were seriously considered.

- 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?

No substantial impact on small business has been found.

Text of Proposed Rulemaking

ITEM 1. Rescind and reserve **641—Chapter 158**.

RACING AND GAMING COMMISSION[491]

Regulatory Analysis

Notice of Intended Action to be published: 491—Chapters 13 and 14
“Sports Wagering; Fantasy Sports Contests”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 99E.3 and 99F.4
State or federal law(s) implemented by the rulemaking: Iowa Code chapters 99F and 99E

Public Hearing

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

November 6, 2024
9 a.m.

6200 Park Avenue, Suite 100
Des Moines, Iowa

Public Comment

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

Barb Blake
Iowa Racing and Gaming Commission
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321
Email: barb.blake@iowa.gov

Purpose and Summary

Item 1 enhances licensee requirements for messaging to applicants/customers with regard to underage wagering and account sharing.

Item 2 clarifies licensee requirements by removing the requirement to utilize a list in determining prohibited players, which effectively reverts the rule to language that was present prior to recent rulemaking.

Item 3 resolves issues and concerns with a previously delayed rulemaking process.

Item 4 resolves issues and concerns with a previously delayed rulemaking process.

Item 5 resolves issues and concerns with a previously delayed rulemaking process.

Item 6 clarifies requirements for geolocation testing and auditing.

Item 7 resolves issues and concerns with a previously delayed rulemaking process.

Item 8 clarifies licensee requirements by removing the requirement to utilize a list in determining prohibited players, which effectively reverts the rule to language that was present prior to recent rulemaking.

Item 9 clarifies licensee requirements for account verification at registration.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

No costs are known to be associated with this proposed rulemaking.

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

The betting public and stakeholders will benefit from the proposed rulemaking.

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

- Quantitative description of impact:

The Commission discerns no quantitative impact.

- Qualitative description of impact:

The Commission discerns no qualitative impact.

3. Costs to the State:

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

There are no known costs.

- Anticipated effect on state revenues:

There is no effect on state revenues.

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

The cost of inaction would be confusion and potential administrative and criminal violations amongst the wagering public and the licensees.

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

There are none.

6. Alternative methods considered by the agency:

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

Alternative rules were previously Adopted and Filed; however, they were rejected and placed on a Session Delay.

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

Stakeholders have again collaborated and are in agreement that this is the most efficient process for stakeholders and the Commission.

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?

There is no effect on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind subrule 13.2(4) and adopt the following **new** subrule in lieu thereof:

13.2(4) *Public notice.*

a. The public shall have access to the sports wagering rules, available wagers, odds or payouts, the payout period, and the source of the information used to determine the outcome of a sports wager.

All licensees and advance deposit sports wagering operators shall require participants to follow the rules of play. The sports wagering rules shall be:

- (1) Displayed in the licensee's sports wagering area.
- (2) Posted on the Internet site or mobile application used to conduct advance deposit sports wagering.
- (3) Included in any terms and conditions disclosure statements of the advance deposit sports wagering system.
 - b.* During account registration and each time the user logs in, advance deposit sports wagering operators shall display the following information on any interface that accepts wagers:
 - (1) Account sharing is prohibited.
 - (2) Persons under the age of 21 are prohibited from wagering.
 - (3) Any other disclosures, as required by the administrator.

ITEM 2. Rescind paragraphs 13.2(7)“a”,13.2(7)“b” and 13.2(7)“d” and adopt the following new paragraphs in lieu thereof:

- a.* To prohibit wagering by coaches, athletic trainers, officials, players, or other individuals who participate and persons employed in a position with direct involvement with coaches, athletic trainers, officials, players or other individuals who participate in an authorized sporting event in which wagers may be accepted.
- b.* To identify and suspend accounts opened by individuals on behalf of persons under the age of 21.
- d.* To promptly report to the commission, in a format approved by the administrator, any abnormal wagering activity or patterns that may indicate a concern about the integrity of an authorized sporting event or events, and any other conduct with the potential to corrupt a wagering outcome of an authorized sporting event for purposes of financial gain, including but not limited to match fixing, and suspicious or illegal wagering activities, including the use of funds derived from illegal activity, wagers to conceal or launder funds derived from illegal activity, use of agents to place wagers, account sharing, or use of false identification. Integrity-monitoring procedures shall also provide for the sharing of information with other licensees, other governing authorities, and accredited sports governing entities by participating in an integrity-monitoring association or group or by another method as approved by the administrator.

ITEM 3. Rescind subrule 13.5(2) and adopt the following new subrule in lieu thereof:

13.5(2) *Account registration.* A person must have an established account in order to place advance deposit sports wagers. The process for establishing an account is subject to the administrator's approval. An account may be established through on-site registration under procedures previously approved by the administrator or through remote registration. To establish an account, an application for an account shall be signed or otherwise authorized in a manner approved by the administrator, and shall include the applicant's full legal name, principal residential address, date of birth, last four digits of the social security number, and any other information required by the administrator. The account registration process shall also include:

- a.* Age verification to prevent persons under the legal age for sports wagering from establishing an account.
- b.* An applicant verification process that includes an exact match of the following:
 - (1) Date of birth, including month, date and year of birth.
 - (2) The last four digits of the social security number.
 - (3) Last name.
- c.* An applicant verification process that permits a flexible match by allowing the following:
 - (1) First name may include nicknames and abbreviations.
 - (2) Address may include abbreviations.
- d.* Authentication of identification by:
 - (1) Answering knowledge-based questions based on the applicant's public or private data; or

- (2) Verifying that device ID and phone number match the applicant's publicly known data; or
- (3) Comparing of valid government-issued ID to applicant's picture taken at time of account registration; or
- (4) Another method as approved by the administrator.
- e. Verification that the player applicant is not on the statewide self-exclusion list set forth in Iowa Code section 99F.4(22) prior to establishing an account.
- f. Availability and acceptance of a set of terms and conditions that is also readily accessible to the player before and after registration and noticed when updated. Notices shall include, at a minimum, the following:
 - (1) Explanation of rules in which any unrecoverable malfunctions of hardware/software are addressed including, but not limited to, if the unrecoverable malfunction, wagering event cancellation, or other catastrophic malfunction results in the voiding of any wagers.
 - (2) Procedures to deal with interruptions caused by the suspension of data flow from the network server during an event.
 - (3) Specifications advising players to keep their account credentials secure.
 - (4) Statement that no underage individuals are permitted to participate in wagering.
 - (5) Explanation of conditions under which an account is declared inactive and actions undertaken on the account once this declaration is made.
- g. Availability and acceptance of a privacy policy that is also readily accessible to the player before and after registration and noticed when updated and that includes, at a minimum, the following:
 - (1) Statement of information that is collected, the purpose for information collection, and the conditions under which information may be disclosed.
 - (2) Statement that any information obtained in respect to player registration or account establishment must be done in compliance with the privacy policy.
 - (3) Requirement that any information about player accounts which is not subject to disclosure pursuant to the privacy policy must be kept confidential, except where the release of that information is required by law.
 - (4) Requirement that all player information must be securely erased from hard disks, magnetic tapes, solid state memory, and other devices before the device is properly disposed of by the licensee. If erasure is not possible, the storage device must be destroyed.
- h. If an advance deposit sports wagering operator has an agreement with more than one licensee, the advance deposit sports wagering operator shall submit an agreement to the administrator that indicates the manner in which customer net receipts shall be assigned with its licensee partners. The agreement shall include all partnering licensees and their respective qualified sponsoring organizations, and the net receipts shall be allocated using one of the following methods:
 - (1) Make available an option for new remotely registered customers to select the licensee at which net receipts are assigned.
 - (2) Allocate new remotely registered customer net receipts to the licensee which is located nearest to the customer's principal residential address.
 - (3) Distribute all customer receipts evenly between all licensees for which an agreement exists.
 - (4) An alternative allocation agreement that complies with local, state and federal law. The agreement shall be made available for public inspection.

ITEM 4. Rescind paragraphs 13.5(2)“b” and 13.5(2)“e” and adopt the following new paragraphs in lieu thereof:

- b. Location detection procedures to reasonably detect and dynamically monitor the location of a player attempting to place any wager or perform other account activities as identified by the advance deposit sports wagering operator or licensee, related to an Iowa authorized account. Account activity-based location detection controls shall be informed by industry best practices and any commission guidelines for the detection of fraud or other unauthorized or illegal activity. The advance deposit sports wagering operator or licensee shall utilize and monitor geolocation activity to detect potential fraudulent and suspicious activity, which shall be reported in accordance with paragraph 13.2(7)“d.”

A player outside the permitted boundary attempting to make a wager shall be rejected, and the player shall be notified. The confidence radius shall be entirely located within the permitted boundary.

e. Authentication for login using a multifactor authentication process or other secure alternative means as authorized by the commission. After successful login, multifactor authentication will need to be performed at least every 14 days for each unique device. Processes for retrieving lost usernames and passwords shall be available, secure, and clearly disclosed to the player. Players shall be allowed to change their passwords.

ITEM 5. Rescind subrule 13.5(7) and adopt the following **new** subrule in lieu thereof:

13.5(7) *Expiration or termination of an Iowa Code section 99F.7A operating agreement.* In the event an advance deposit sports wagering operating agreement between a licensee under Iowa Code section 99F.7A and another entity expires, terminates, or is no longer valid, notice of termination must be given to the commission and all customers affiliated with the licensee. A customer shall be given an opportunity to close an account. If the advance deposit sports wagering operator has an operating agreement with other licensees in the state of Iowa, the customer shall have the option to select another partner licensee to which their net receipts shall be assigned, or the customer's net receipts shall be assigned to any remaining partner licensees in accordance with an agreement submitted to the administrator pursuant to paragraph 13.5(2) "h."

ITEM 6. Rescind paragraphs **13.6(3)"b"** and **13.6(3)"c"** and adopt the following **new** paragraphs in lieu thereof:

b. A geolocation system and integrity test shall be performed annually on the advance deposit wagering system.

(1) The testing organization must be independent of the licensee and the licensed geolocation vendor and shall be qualified by the administrator.

(2) The geolocation test shall be completed and the results submitted no later than March 31 of each year.

(3) Geolocation testing shall review existing licensee procedures for detecting and reporting fraudulent activity associated with any account activity detected by the geolocation system.

c. At the discretion of the administrator, additional assessments or specific testing criteria may be required.

ITEM 7. Rescind subrule 14.7(2) and adopt the following **new** subrule in lieu thereof:

14.7(2) Customer verification.

a. A customer verification process shall include an exact match of the following:

(1) Date of birth, including month, date and year of birth.

(2) The last four digits of the social security number.

(3) Last name.

b. A customer verification process shall permit a flexible match by allowing the following:

(1) First name may include nicknames and abbreviations.

(2) Address may include abbreviations.

c. A customer verification process shall authenticate identification by the following:

(1) Answering knowledge-based questions based on the applicant's public or private data; or

(2) Verifying that device ID and phone number match the applicant's publicly known data; or

(3) Comparing a valid government-issued ID to a photo of the applicant taken at the time of account registration; or

(4) Another method as approved by the administrator.

ITEM 8. Rescind paragraph **14.8(1)"c"** and adopt the following **new** paragraph in lieu thereof:

c. Restriction of entries from coaches, officials, athletes, contestants, or other individuals who participate in a game or contest that is the subject of an Internet fantasy sports contest in which the outcome is determined, in whole or in part, by the accumulated statistical results of a team of individuals in the game or contest in which they participate.

ITEM 9. Rescind paragraph **14.8(5)“h”** and adopt the following **new** paragraph in lieu thereof:

h. During account registration and each time the user logs in, fantasy sports contest service providers shall display the following information on any interface that accepts fantasy sports contest entries:

- (1) Account sharing is prohibited.
- (2) Persons under the age of 21 are prohibited from entering fantasy sports contests.
- (3) Any other disclosures, as required by the administrator.

Regulatory Analysis

Notice of Intended Action to be published: 761—Chapter 145
“Automated Traffic Enforcement Mobile Systems”

Iowa Code section(s) or chapter(s) authorizing rulemaking: 321P.3 as enacted by 2024 Iowa Acts, House File 2681

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 321P as enacted by 2024 Iowa Acts, House File 2681

Public Hearing

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

November 8, 2024
10 to 10:30 a.m.

[Microsoft Teams link](#)
Phone: 515.817.6093
Conference ID: 169 911 106

Public Comment

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

Chris Poole
800 Lincoln Way
Ames, Iowa 50010
Email: chris.poole@iowadot.us

Purpose and Summary

This proposed chapter establishes conditions, procedures, and responsibilities for the use of automated traffic enforcement mobile systems to issue citations for violations of the speed limit. These rules apply to local authorities using or planning to use an automated traffic enforcement mobile system.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

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

No class of persons will bear the costs.

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

All Iowans will benefit from rules governing the operation of automated traffic enforcement mobile systems.

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:

Local agencies wishing to operate a mobile system would bear the costs associated with procuring the equipment, applying for an operating permit, and submitting an annual report for each location where a mobile system was used during the previous calendar year. Local agencies would also bear the costs associated with moving or removing a mobile system from its location no longer than three weeks after it began operating at that location.

- Qualitative description of impact:
The chapter benefits all Iowans by providing clear, transparent guidelines for the oversight, operation, and administration of automated traffic enforcement mobile systems.
- 3. Costs to the State:
 - Implementation and enforcement costs borne by the agency or any other agency:
Negligible implementation and enforcement costs exist beyond those already needed to implement and enforce Iowa Code chapter 321P.
 - Anticipated effect on state revenues:
No effect on state revenues is anticipated.
- 4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:
The benefits of the proposed rules outweigh the costs of implementing the chapter.
- 5. Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:
No less costly or less intrusive methods exist.
- 6. Alternative methods considered by the agency:
 - Description of any alternative methods that were seriously considered by the agency:
The Department did not consider any alternative methods.
 - Reasons why alternative methods were rejected in favor of the proposed rulemaking:
Rules are required by statute.

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?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Adopt the following new761—Chapter 145:

CHAPTER 145 AUTOMATED TRAFFIC ENFORCEMENT MOBILE SYSTEMS

761—145.1(90GA, HF2681) General.

145.1(1) Purpose and applicability. This chapter establishes conditions, procedures, and responsibilities for the use of automated traffic enforcement mobile systems to issue citations for violations of the speed limit. These rules apply to local authorities using or planning to use an automated traffic enforcement mobile system.

145.1(2) Overview.

a. Mobile systems must comply with Iowa Code chapter 321P as enacted by 2024 Iowa Acts, House File 2681.

b. A local authority's use of a mobile system is subject to the population limit identified in Iowa Code section 321P.3(2) as enacted by 2024 Iowa Acts, House File 2681, section 3. However, a local authority of any population may use a mobile system to issue warnings in accordance with Iowa Code section 321P.3(3) as enacted by 2024 Iowa Acts, House File 2681, section 3.

c. Use of a mobile system is limited to locations identified in Iowa Code section 321P.3(2) as enacted by 2024 Iowa Acts, House File 2681, section 3.

d. Mobile systems are to be situated in a manner that:

- (1) Maintains a safe environment for all road users.
- (2) Allows for free passage along the roadway right-of-way.
- (3) Minimizes the potential to cause backups or delays.
- (4) Does not obstruct the view of other road users or traffic control devices.

145.1(3) Contact information. Information relating to this chapter may be obtained from the Traffic and Safety Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010, or at www.iowadot.gov/traffic.

145.1(4) Definitions. The definitions in Iowa Code section 321P.1 as enacted by 2024 Iowa Acts, House File 2681, section 1, apply to this chapter. In addition:

"Automated traffic enforcement mobile system" or "mobile system" means a vehicle, trailer, or other portable apparatus containing one or more automated or remote systems for traffic law enforcement.

"Interstate road" means the same as "interstate roads" as defined in Iowa Code section 306.3.

"Location" means a street address, a block number, an intersection, or a mile marker and includes the direction of traffic being monitored.

"Primary road" means the same as "primary roads" as defined in Iowa Code section 306.3.

761—145.2(90GA,HF2681) Conditions for mobile systems.**145.2(1) Placement.**

a. Except when used in a construction zone, a mobile system shall not be placed or parked:

(1) Less than 15 feet from any traffic lane of an interstate road unless shielded by a crashworthy barrier.

(2) On the outside shoulder of any non-interstate primary road for longer than 72 hours unless shielded by a crashworthy barrier.

(3) Within the median or on the inside shoulder of any road.

(4) Less than two feet behind the back of a curb on any road.

(5) Less than two feet from the edge of any traffic lane on any road.

b. When used in a construction zone, a mobile system shall be shielded by a crashworthy barrier unless it is placed or parked more than 15 feet from any active traffic lane.

145.2(2) Duration of use. Except when used in a construction zone, a mobile system shall not be used in one location for longer than three consecutive weeks or be used in one location for more than 21 days in any 45-day period. When used in a construction zone, a mobile system may be used in one location for the duration of construction activities.

145.2(3) Public notice. A local authority operating a mobile system shall provide information regarding where and when a mobile system will be used on the local authority's Internet site or social media outlets.

145.2(4) Vehicles and trailers. A vehicle or trailer used as a mobile system shall be operated by a law enforcement agency, marked with distinguishing decals, and identified by a distinguishing license plate affixed to the vehicle or trailer.

761—145.3(90GA, HF2681) Permitting.

145.3(1) *Initial permit.* A local authority may apply for a permit by submitting a request to the department, following the procedure outlined in Iowa Code section 321P.2(2) as enacted by 2024 Iowa Acts, House File 2681, section 2, for each location where a mobile system is proposed to be used. The department will not issue an initial permit before July 1, 2026.

145.3(2) *Updating an existing permit.* A local authority holding a permit may apply to update the permit with one or more additional locations by submitting a request to the department, following the procedure outlined in Iowa Code section 321P.2(2) as enacted by 2024 Iowa Acts, House File 2681, section 2, for each location where a mobile system is proposed to be used.

145.3(3) *Department review.* The department will review the application and will approve or deny each requested location based on the department's determination that use of a mobile system is appropriate, necessary, and the least restrictive means to address the critical traffic safety issues at that location. Incomplete applications will be returned to the applicant. If approval is granted, the department will issue a permit listing all approved locations.

145.3(4) *Exception for warnings.* Use of a mobile system at a location solely for the issuance of warnings does not require a permit.

761—145.4(90GA, HF2681) Annual report.

145.4(1) A local authority using a mobile system shall submit to the department and post an annual report as described in Iowa Code section 321P.5(2) as enacted by 2024 Iowa Acts, House File 2681, section 5.

145.4(2) The report must also include the following information from the previous calendar year for each location listed in the permit:

- a. Number of days the mobile system was in use.
- b. Count of all vehicles traveling past the mobile system while it was in use.
- c. Speed distribution data for all vehicles traveling past the mobile system while it was in use.
- d. Description of any changes in traffic patterns, roadway infrastructure, zoning, or land use.
- e. Identification of any other safety countermeasures that have been implemented.

761—145.5(90GA, HF2681) Continued use of mobile system.

145.5(1) *Reevaluation.* The department will utilize information collected from the annual report to assist in annually evaluating the ongoing need for a mobile system at each location listed in the permit. Continued approval of each location will be contingent on:

- a. Effectiveness of the mobile system in addressing the critical traffic safety issues.
- b. Changes in traffic speeds, volumes, or patterns.
- c. Changes in roadway infrastructure.
- d. Changes in zoning or land use.
- e. Implementation of other safety countermeasures.
- f. Appropriate administration of the mobile system by the local authority.
- g. The local authority's compliance with these rules and Iowa Code chapter 321P as enacted by 2024 Iowa Acts, House File 2681.

145.5(2) *Reserve the right.* The department reserves the right to rescind a permit, remove a location from a permit, or require modification of a mobile system, as deemed appropriate.

761—145.6(90GA, HF2681) Appeal process. A local authority may appeal a decision made by the department under this chapter by submitting a written explanation of the issues for appeal and any supporting information to the director of transportation or director's designee (director). Once the director receives the appeal, the director has 30 days to respond. The director's decision is final agency action.

These rules are intended to implement Iowa Code chapter 321P as enacted by 2024 Iowa Acts, House File 2681.

ARC 8253C

LABOR SERVICES DIVISION[875]**Notice of Intended Action****Proposing rulemaking related to consultative services
and providing an opportunity for public comment**

The Labor Commissioner hereby proposes to rescind Chapter 8, “Consultative Services,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 88.5.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Executive Order 10.

Purpose and Summary

This proposed rulemaking, in accordance with Executive Order 10, requires a consultation division of the Iowa Occupational Safety and Health Administration (OSHA) that educates about work safety apart from the issuance of citations or penalties.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on August 21, 2024. A public hearing was held on the following date(s):

- September 10, 2024

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Division of Labor Services for a waiver of the discretionary provisions, if any, pursuant to 481—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking. Written or oral comments in response to this rulemaking must be received by the Division no later than 4:30 p.m. on November 6, 2024. Comments should be directed to:

Mitchell Mahan
Labor Services Division
6200 Park Avenue
Des Moines, Iowa 50321
Phone: 515.443.1051
Email: mitchell.mahan@dia.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

November 5, 2024 8:30 to 9 a.m.	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa
November 6, 2024 8:30 to 9 a.m.	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Division and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 875—Chapter 8 and adopt the following **new** chapter in lieu thereof:

CHAPTER 8
CONSULTATIVE SERVICES

875—8.1(88) Purpose and scope. This chapter contains procedures for the division of labor services, bureau of consultation and education, to provide consultative services to private and public employers.

8.1(1) Services are available at no cost to employers to assist employers in establishing an effective occupational safety and health management system in order to provide employment and a place of employment that are safe and healthful. The goal is to prevent injuries and illnesses that may result from exposure to hazardous work practices and conditions. The principal assistance will be provided at the employer's work site, but off-site assistance may also be provided. Within the scope of the employer's request, the consultant will evaluate the employer's program for providing employment and a place of employment that are safe and healthful; identify specific hazards in the workplace; and provide appropriate advice and assistance in establishing or improving the employer's safety and health management system and in correcting any hazardous conditions identified. Assistance may include education and training of the employer, the employer's supervisors, and the employer's other employees to make the employer self-sufficient in ensuring safe and healthful work and working conditions.

8.1(2) Consultation is independent of Iowa OSHA enforcement, and the discovery of hazards will not mandate citations or penalties. However, the employer has a statutory obligation to protect employees, and, in certain instances, the employer will be required to take necessary protective action. An employer that corrects the hazards identified by the consultant during a comprehensive workplace survey, implements certain core elements of an effective safety and health management system, and commits to complete other core elements of an effective safety and health program may qualify for exemption from certain enforcement activities.

875—8.2(88) Definitions.

"Act" means the Iowa occupational safety and health Act, Iowa Code chapter 88.

“Compliance officer” means a compliance safety and health officer employed by Iowa OSHA enforcement.

“Consultant” means an employee of the bureau of consultation and education of the division of labor services.

“Consultation” means all activities related to the provision of consultative assistance under this chapter, including off-site consultation and on-site consultation.

“Division” means the division of labor services of the department of inspections, appeals, and licensing.

“Education” means planned and organized activity by a consultant to impart information to employers and employees to enable them to establish and maintain employment and a place of employment that are safe and healthful.

“Employee representative” means the authorized representative of employees at a site where there is a recognized labor organization representing employees.

“Hazard correction” means the elimination or control of a workplace hazard in accordance with the requirements of the Act and rules.

“Imminent danger” means a condition or practice in a place of employment that could reasonably be expected to cause death or serious physical harm immediately or before the danger can be eliminated.

“Iowa OSHA enforcement” means the unit of the division that enforces the occupational safety and health Act.

“List of hazards” means a list of all serious hazards that are identified by the consultant and the correction due dates agreed upon by the employer and the consultant.

“Off-site consultation” means consultation provided away from an employer’s work site by means such as training, education, telephone, and correspondence.

“On-site consultation” means consultation provided during a visit to an employer’s work site. “On-site consultation” includes a written report to the employer on the findings and recommendations resulting from the visit and may include training and education needed to address hazards or potential hazards at the work site.

“Other-than-serious hazard” means any condition or practice that would be classified as an other-than-serious violation of applicable standards based on criteria contained in the current Iowa Field Operations Manual.

“Programmed inspection” means an inspection scheduled based on objective or neutral criteria as set forth in the Iowa Field Operations Manual.

“Recognition and exemption program” means an achievement recognition program to recognize an employer that operates an exemplary program that results in the immediate and long-term prevention of job-related injuries and illnesses at a workplace.

“Serious hazard” means a condition or practice that would be classified as a serious violation of applicable standards, except that the element of employer knowledge will not be considered.

“Training” means the planned and organized activity of a consultant to impart skills, techniques and methodologies to employers and their employees to assist them in establishing and maintaining employment and a place of employment that are safe and healthful.

875—8.3(88) Requesting and scheduling of on-site consultation visit.

8.3(1) *Employer requests.* On-site consultation will be provided only upon the request of the employer. Any employer may specify a more limited scope for the visit by indicating working conditions, hazards, or situations on which on-site consultation shall be focused. When limited requests are made, the consultant will limit review and provide assistance only with respect to the specified working conditions, hazards, or situations. However, if in the course of the on-site visit the consultant observes hazards that are outside the scope of the request, the consultant shall treat the hazards as though they were within the scope of the request.

8.3(2) *Relationship to enforcement.* An employer may request on-site consultation to assist in the abatement of hazards cited during an enforcement inspection. However, on-site consultation may not

take place after an enforcement inspection until the conditions set forth in paragraph 8.5(2) “c” have been met.

8.3(3) *Scheduling priority.* Scheduling priorities will be in accordance with the federal Consultation Policy and Procedures Manual.

875—8.4(88) Conducting a visit.

8.4(1) *Preparation.*

- a. The consultant will conduct an on-site consultation visit only after appropriate preparation.
- b. If a request is made during a promotional visit, a consultant may perform on-site consultation activities immediately.

8.4(2) *Structured format.*

- a. An initial on-site consultation visit will consist of an opening conference where the employer will be advised of the responsibilities under state law, an examination of those aspects of the employer’s safety and health program that relate to the scope of the visit, a walk-through of the workplace, and a closing conference. An initial visit may include training and education for employers and employees, if the employer requests the assistance and if the need for the training and education is revealed by the walk-through of the workplace and the examination of the employer’s safety and health program. The consultant will provide a written report to the employer after the consultation.
- b. Additional visits may be conducted as the employer requests to provide needed education and training, assistance with the employer’s safety and health program, or technical assistance in the correction of hazards. Additional visits may also be conducted if necessary to verify the correction of serious hazards identified during previous visits.

8.4(3) *Employee participation.*

- a. The consultant retains the right to confer with individual employees privately during the course of the visit in order to identify and judge the nature and extent of particular hazards within the scope of the employer’s request and to evaluate the employer’s safety and health program. The consultant will explain the necessity for this contact to the employer during the opening conference, and the employer must agree to this contact before a visit can proceed.
- b. Employees, their representatives, and members of a workplace joint safety and health committee may participate in the on-site consultation to the extent desired by the employer. In the opening conference, the consultant shall encourage the employer to allow employee participation to the fullest extent practicable.
- c. An employee representative of affected employees must be afforded an opportunity to accompany the consultant and the employer’s representative during the physical inspection of the workplace.
- d. If there is no employee representative, if the consultant is unable with reasonable certainty to identify an employee representative, or if the employee representative declines the offer to participate, the consultant must confer with a reasonable number of employees concerning matters of occupational safety and health.
- e. The consultant is authorized to deny the right to participate to any person whose conduct interferes with the orderly conduct of the visit.

8.4(4) *Opening and closing conferences.*

- a. In the opening conference, the consultant will explain the relationship between on-site consultation and OSHA enforcement activity, will explain the obligation to protect employees in the event that certain hazardous conditions are identified, and will emphasize the employer’s obligation to post the list of hazards.
- b. The consultant will encourage a joint opening conference with the employer and employee representatives. If there is an objection to a joint conference, the consultant will conduct separate conferences with the employer and employee representatives. The consultant must inform employees at the opening conference of the purpose of the consultation visit.

c. At the conclusion of the consultation visit, the consultant will conduct a closing conference with the employer and employee representatives, jointly or separately. The consultant will describe hazards identified during the visit and other pertinent issues related to employee safety and health.

8.4(5) *On-site activity.*

a. During the on-site consultation, the consultant will focus primarily on conditions, hazards, or situations for which the employer requested assistance. An employer may expand or reduce the scope of the request at any time during the on-site consultation. If the employer requests an expansion of the scope, the consultant will expand the scope immediately if scheduling priorities permit and the consultant is prepared. If the employer's request for expansion necessitates further preparation by the consultant or the expertise of another consultant, or if other employer requests may merit higher priority, the consultant will refer the request to the consultation manager for scheduling. If the scope of the visit is reduced, the employer shall correct serious hazards that were already identified and provide appropriate proof of correction.

b. The consultant will advise the employer of the employer's obligations and responsibilities under applicable law.

c. Within the scope of the employer's request, the consultant will review the employer's safety and health management system and provide advice on modifications or additions to make the program more effective.

d. The consultant will identify and provide advice on the correction of hazards included in the employer's request and any other safety or health hazards observed in the workplace. The consultant will conduct necessary sampling, testing, and analysis to confirm the existence of a safety or health hazard.

e. Advice and technical assistance on the correction of identified safety and health hazards may be provided to employers during and after the on-site consultation. The consultant may provide materials on approaches, means, techniques, and items commonly utilized for the elimination or control of hazards. The consultant will advise the employer of additional sources of assistance, if known.

f. When a hazard is identified in the workplace, the consultant will indicate to the employer the consultant's best judgment as to whether the hazard would be classified as serious hazard or other-than-serious hazard.

g. If the consultant determines that an identified serious hazard exists, the consultant will assist the employer to develop a specific plan to correct the hazard. The chief of the bureau of consultation and education will provide an expeditious informal discussion regarding the period of time established for the correction of a hazard or any other substantive findings of the consultant if the employer requests the informal discussion within 15 working days from receipt of the consultant's report.

h. As a condition for receiving the consultation service, the employer must agree to post the list of hazards accompanying the consultant's written report and to notify affected employees when hazards are corrected. The employer must, upon receipt, post the unedited list of hazards in a prominent place where it is readily observable by all affected employees for three working days or until the hazards are corrected, whichever is later. A copy of the list of hazards shall be made available to the employee representative who participated in the visit.

8.4(6) *Employer's obligations.*

a. An employer must take immediate action to eliminate employee exposure to a hazard that presents an imminent danger to employees. If the employer fails to take the necessary action, the chief of the bureau of consultation and education shall immediately notify the affected employees and the labor commissioner or the labor commissioner's designee.

b. An employer must also take the necessary action to eliminate or control employee exposure to any identified serious hazard and meet the employee notice requirements of paragraph 8.4(5) "h." In order to demonstrate that the necessary action is being taken, an employer may be required to submit periodic reports, permit a follow-up visit, or take similar action.

c. The chief of the bureau of consultation and education may grant an extension of time for the correction of a serious hazard when:

- (1) The employer files a request for extension;

(2) The employer demonstrates it made a good-faith effort to correct the hazard within the established time frame;

(3) The employer provides evidence that correction is not complete because of factors beyond the employer's reasonable control; and

(4) The employer provides evidence that the employer is taking all available interim steps to safeguard the employees against the hazard during the correction period.

d. If the employer fails to take the action necessary to correct a serious hazard within the established time frame or any extensions thereof, the chief of the bureau of consultation and education will immediately notify the labor commissioner or the labor commissioner's designee.

e. The employer will confirm in writing to the chief of the bureau of consultation and education that the hazards have been corrected unless the consultant otherwise confirms correction of the hazards.

8.4(7) *Written report.* For each visit that results in substantive findings or recommendations, a written report will be prepared and sent to the employer. The report will include the following elements as applicable:

- a.* A restatement of the employer's request;
- b.* A description of the working conditions examined by the consultant;
- c.* An evaluation of the employer's safety and health management system;
- d.* Recommendations for making the safety and health program more effective;
- e.* Identification, description, and classification of each hazard;
- f.* Reference to applicable standards and regulations;
- g.* Correction date for each serious hazard;
- h.* Suggested means or approaches to correct hazards; and
- i.* Recommendations for additional assistance, such as medical or engineering advice.

8.4(8) *Confidentiality.* The bureau of consultation and education will provide, when requested, program information to the U.S. Occupational Safety and Health Administration, including information that identifies employers that have requested consultation services.

875—8.5(88) Relationship to enforcement.

8.5(1) *Separation of functions.* Consultation shall be conducted independently of Iowa OSHA enforcement. Except as noted in subrule 8.5(3), neither the identity of an employer requesting on-site consultation nor the file or report from the consultation activity will be provided to Iowa OSHA enforcement unless the employer fails to take the necessary action to protect employees from a serious hazard or imminent danger.

8.5(2) *Effect upon scheduling.*

a. An on-site consultation already in progress will have priority over compliance inspections by Iowa OSHA enforcement except as provided in paragraph 8.5(2) "*b.*" The consultant and the employer will notify the compliance officer that an on-site consultation is in progress and will request delay of the inspection until after the on-site consultation is completed.

b. The consultant will terminate an on-site consultation if one of the following compliance inspections by Iowa OSHA enforcement is about to take place:

- (1) Imminent danger investigation.
- (2) Fatality/catastrophe investigation.
- (3) Complaint or referral investigation.
- (4) Other critical inspection as determined by the labor commissioner.

c. An on-site consultation shall not take place while an enforcement inspection is in progress at the establishment. An enforcement inspection will be deemed "in progress" from the time a compliance officer initially seeks entry to the workplace to the end of the closing conference. If the employer denied the compliance officer entry to the work site, an enforcement inspection is "in progress" until the inspection is concluded, the commissioner determines that a warrant to enter will not be sought, or the commissioner determines that allowing a consultative visit to proceed is in the best interest of employee safety and health. An on-site consultation shall not take place subsequent to an enforcement inspection

until the employer has been notified that no citations will be issued, or if a citation is issued, on-site consultation will take place only with regard to those citation items that have become final orders.

d. The recognition and exemption program operated by the bureau of consultation and education provides incentives and support to high-hazard employers to work with employees to develop, implement, and continuously improve the effectiveness of a safety and health management system.

(1) Programmed enforcement inspections at a work site may be deferred while the employer is working to achieve recognition status if the following conditions are met:

1. An employer requested participation in a recognition and exemption program;
2. A consultant has conducted an on-site consultation covering all conditions and operations related to occupational safety and health;
3. An employer corrected all hazards identified during the consultation visit within established time frames;
4. An employer has begun to implement all of the elements of an effective safety and health management system; and
5. An employer agrees to request an on-site consultation if major changes in working conditions or work processes occur that may introduce new hazards.

(2) Employers that meet all the requirements for recognition and exemption will be removed from the Iowa OSHA enforcement programmed inspection schedules for at least one year from the date of the certificate of recognition.

(3) Iowa OSHA enforcement shall continue to make the inspections listed below at sites that achieved recognition and exemption status and at sites that have received deferrals:

1. Imminent danger;
2. Fatality/catastrophe; and
3. Formal complaint.

8.5(3) *Effect upon enforcement.*

a. The advice of the consultant and the consultant's written report will not be binding upon a compliance officer in a subsequent enforcement inspection. In a subsequent enforcement inspection, a compliance officer is not precluded from issuing citations and proposing penalties for hazardous conditions or violations.

b. The hazard identification and correction assistance given by the consultant, the failure of the consultant to point out a specific hazard, and errors or omissions by the consultant shall not:

- (1) Be binding upon a compliance officer;
- (2) Affect the regular conduct of a compliance inspection;
- (3) Preclude the finding of alleged violations and the issuance of citations; or
- (4) Act as a defense to any enforcement action.

c. In the event of a subsequent enforcement inspection, the employer is not required to inform the compliance officer of the prior consultation visit. The employer is not required to provide a copy of the consultant's written report to the compliance officer, except to the extent that disclosure of information contained in the report is required by 29 CFR 1910.1020. During a subsequent enforcement action, if Iowa OSHA enforcement independently determines there is reason to believe that the employer failed to correct serious hazards identified during the consultation visit, created the same hazards again, or made false statements to the bureau of consultation and education in connection with the consultation program, Iowa OSHA enforcement may exercise its authority to obtain the consultation report.

d. If the employer chooses to provide a copy of the consultant's report to the compliance officer, the report may be used to determine the extent to which an inspection is required and as a factor in determining proposed penalties. Iowa OSHA enforcement may impose minimal penalties if a consultant previously identified a hazard and the employer is complying with the consultant's recommendations in good faith.

These rules are intended to implement Iowa Code chapter 88.

ARC 8254C**LABOR SERVICES DIVISION[875]****Notice of Intended Action****Proposing rulemaking related to OSHA discrimination against employees
and providing an opportunity for public comment**

The Labor Commissioner hereby proposes to rescind Chapter 9, “Discrimination Against Employees,” and to adopt a new Chapter 9, “OSHA Discrimination Against Employees,” Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 88.5.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Executive Order 10.

Purpose and Summary

This rulemaking, in accordance with Executive Order 10, proposes a new Chapter 9 that protects employees from retaliation when employees make a work safety complaint to the Iowa Occupational Safety and Health Administration (OSHA).

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on August 21, 2024. A public hearing was held on the following date(s):

- September 10, 2024

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Division of Labor Services for a waiver of the discretionary provisions, if any, pursuant to 481—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking. Written or oral comments in response to this rulemaking must be received by the Division no later than 4:30 p.m. on November 6, 2024. Comments should be directed to:

Mitchell Mahan
Labor Services Division
6200 Park Avenue
Des Moines, Iowa 50321
Phone: 515.443.1051
Email: mitchell.mahan@dia.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

November 5, 2024 8:30 to 9 a.m.	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa
November 6, 2024 8:30 to 9 a.m.	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Division and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 875—Chapter 9 and adopt the following **new** chapter in lieu thereof:

CHAPTER 9
OSHA DISCRIMINATION AGAINST EMPLOYEES

875—9.1(88) Complaints and proceedings under or related to the Iowa occupational safety and health Act.

9.1(1) Complaints about occupational safety and health, if made in good faith, are related to the Iowa occupational safety and health Act, Iowa Code chapter 88, hereinafter referred to as the Act, and an employee is protected against discharge or discrimination caused by a complaint to the employer.

9.1(2) If an employee, with no reasonable alternative, refuses in good faith to be exposed to a dangerous condition, the employee is protected against subsequent discrimination if the following conditions are met:

a. The condition causing the employee's apprehension of death or injury must be of such a nature that a reasonable person, under the circumstances then confronting the employee, would conclude that there is a real danger of death or serious injury.

b. The employee, where possible, first sought to:

(1) Eliminate the danger through resorting to regular statutory enforcement channels unless there has been insufficient time due to the urgency of the situation, or

(2) Obtain from the employer a correction of the dangerous condition but was unable to do so.

9.1(3) Discharge of, or discrimination against, any employee because the employee "has testified or is about to testify" in proceedings under or related to the Act extends to any statements given in the course of judicial, quasi-judicial, and administrative proceedings, including inspections, investigations, and administrative rulemaking or adjudicative functions. If the employee is giving or is about to give testimony in any proceeding under or related to the Act, the employee would be protected against discrimination resulting from such testimony.

9.1(4) An employee need not directly institute the proceedings. It is sufficient if the employee sets into motion activities of others that result in proceedings under or related to the Act.

9.1(5) An employer's failure to pay employees for time during which the employees are engaged in walkaround inspections or in other inspection-related activities, such as responding to questions of compliance officers or participating in the opening and closing conferences, is discriminatory under Iowa Code section 88.9(3) so long as neither the number of employees participating nor the time required to express employee concerns is excessive.

9.1(6) The employee's engagement in protected activity need not be the sole consideration behind discharge or other adverse action. If protected activity was a substantial reason for the action, or if the discharge or other adverse action would not have taken place "but for" engagement in protected activity, Iowa Code section 88.9(3) has been violated.

9.1(7) The prohibitions of Iowa Code section 88.9(3) are not limited to actions taken by employers against their own employees. A person may be chargeable with discriminatory action against an employee of another person. Iowa Code section 88.9(3) extends to such entities as organizations representing employees for collective bargaining purposes, employment agencies, or any other person in a position to discriminate against an employee.

875—9.2(88) Unprotected activities distinguished.

9.2(1) Actions taken by an employer or others that adversely affect an employee may be predicated upon nondiscriminatory grounds. The proscriptions of Iowa Code section 88.9(3) apply when the adverse action occurs because the employee has engaged in protected activities. An employee's engagement in activities protected by the Act does not automatically render the employee immune from discharge or discipline for legitimate reasons or from adverse action dictated by nonprohibited considerations.

9.2(2) An employer would not ordinarily be in violation of Iowa Code section 88.9(3) by taking action to discipline an employee for refusing to perform normal job activities because of alleged safety or health hazards.

9.2(3) Disciplinary measures taken by employers solely in response to employee refusal to comply with appropriate safety rules and regulations will not ordinarily be regarded as discriminatory action prohibited by Iowa Code section 88.9(3).

875—9.3(88) Filing of complaint for discrimination.

9.3(1) A complaint of Iowa Code section 88.9(3) discrimination may be filed by the employee or by a representative authorized to do so on the employee's behalf. No particular form of complaint is required. A complaint should be filed with the labor commissioner.

9.3(2) Complaints not filed within 30 days of an alleged violation will ordinarily be presumed to be untimely. However, there may be circumstances that would justify tolling of the 30-day period on recognized equitable principles or because of strongly extenuating circumstances (e.g., where the employer has concealed or misled the employee regarding the grounds for discharge or other adverse action or where the discrimination is in the nature of a continuing violation). The pendency of grievance-arbitration proceedings or filing with another agency, among others, are circumstances that do not justify tolling of the 30-day period.

9.3(3) Withdrawal of complaint. Attempts by an employee to withdraw a previously filed complaint will not necessarily result in termination of the labor commissioner's investigation. However, a voluntary and uncoerced request from a complainant to withdraw the complaint will be given careful consideration and substantial weight.

875—9.4(88) Notice of determination. Iowa Code section 88.9(3) provides that within 90 days of the filing of a complaint, the labor commissioner is to notify a complainant whether prohibited discrimination occurred. This 90-day provision is considered to be directory in nature.

875—9.5(88) Arbitration or other agency proceedings.

9.5(1) The labor commissioner's jurisdiction to entertain complaints related to Iowa Code section 88.9(3) complaints is independent of the jurisdiction of the other agencies or bodies. The labor commissioner may file action in district court regardless of the pendency of other proceedings. However,

due deference should be paid to the jurisdiction of other forums established to resolve disputes that may also be related to complaints under Iowa Code section 88.9(3).

9.5(2) Postponement of determination is justified where the rights asserted in other proceedings are substantially the same as rights under Iowa Code section 88.9(3).

9.5(3) A determination to defer to the outcome of other proceedings initiated by a complainant must necessarily be made on a case-to-case basis, after careful scrutiny of all available information.

These rules are intended to implement Iowa Code sections 84A.1, 84A.2, 88.2, and 88.9(3).

ARC 8255C

LABOR SERVICES DIVISION[875]

Notice of Intended Action

Proposing rulemaking related to sanitation and shelter rules for railroad employees and providing an opportunity for public comment

The Labor Commissioner hereby proposes to rescind Chapter 29, “Sanitation and Shelter Rules for Railroad Employees,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 88.5.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Executive Order 10.

Purpose and Summary

This rulemaking, in accordance with Executive Order 10, proposes a new Chapter 29 that requires railroads to have minimum sanitary and shelter standards for its employees.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on August 21, 2024. A public hearing was held on the following date(s):

- September 10, 2024

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Division of Labor Services for a waiver of the discretionary provisions, if any, pursuant to 481—Chapter 6.

Public Comment

Any interested person may submit written or oral comments concerning this proposed rulemaking. Written or oral comments in response to this rulemaking must be received by the Division no later than 4:30 p.m. on November 6, 2024. Comments should be directed to:

Mitchell Mahan
Labor Services Division
6200 Park Avenue
Des Moines, Iowa 50321
Phone: 515.443.1051
Email: mitchell.mahan@dia.iowa.gov

Public Hearing

Public hearings at which persons may present their views orally or in writing will be held as follows:

November 5, 2024 8:30 to 9 a.m.	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa
November 6, 2024 8:30 to 9 a.m.	Lake Conference Room 6200 Park Avenue, Suite 100 Des Moines, Iowa

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the Division and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 875—Chapter 29 and adopt the following **new** chapter in lieu thereof:

CHAPTER 29 SANITATION AND SHELTER RULES FOR RAILROAD EMPLOYEES

875—29.1(88) Definitions. As used herein or in connection with these rules, the following terms mean:

29.1(1) *Bunk or section house.* Any building or portion thereof, excepting a family dwelling, in which persons employed by railroad companies are furnished sleeping or living accommodations.

29.1(2) *Caboose.* Any car or coach used on a train to carry the train crew.

29.1(3) *Camp car.* Any group of sleeping, dining, kitchen or recreation cars, on or off rail, furnished for the use of any one gang or group of employees.

29.1(4) *Company.* A common carrier railroad company as an employer.

29.1(5) *Employee.* Any person employed by a company to which these rules apply.

29.1(6) *Dressing room.* A room used by employees either as a dressing room, or as a restroom, or for both purposes.

29.1(7) *Number of employees.* Unless otherwise specified, the maximum number of employees going on or coming off shift within any single hour.

29.1(8) *Railroads.* Common carrier railroads.

29.1(9) *Sanitary.* Free from or effective in preventing or checking agencies injurious to health, especially filth and infection.

29.1(10) *Station.* A location where freight or passenger traffic is ordinarily received and delivered and at which an employee is regularly assigned for duty.

29.1(11) Terminal. A location where engine and train crews in yard and train service and switchmen, switch tenders and car clerks are regularly required to report for or relieved from duty.

29.1(12) Toilets. Fixtures such as flush toilets, chemical closets, incinerator-type toilets, or privies for the purpose of defecation unless otherwise specified.

29.1(13) Usual place of employment. The place where an employee works with a reasonable measure of continuity throughout the major part of company service.

29.1(14) Yards. Yards, section headquarters, and locomotive and car shops.

29.1(15) Office work area. A yard office; station; depot; terminal; or freight, baggage and express office that is a permanent or semipermanent stationary facility located on railroad property and a usual place of employment for the performance of clerical or work concerned with or identified with the office functions of the company.

875—29.2(88) Water supply—requirements.

29.2(1) General specifications. Water supplied for domestic and drinking purposes under these regulations will meet the standards of the department of health and human services. Cross-connections between a potable and nonpotable water supply are prohibited.

29.2(2) Drinking water.

a. An adequate supply of cool, clean, sanitary water that is satisfactory for drinking purposes will be made available to all employees.

b. When necessary, this water will be provided in suitable, clean, sterilized and sanitary containers conveniently placed for the use of employees, but not in toilet rooms. Each container will be equipped with an approved type of fountain, approved faucet or other approved dispenser.

c. Either single-service containers or drinking fountains with a sanitary angle head will be used.

29.2(3) Required locations.

a. Drinking water that meets the specifications of subrules 29.2(1) and 29.2(2) will be provided on the following equipment when in use and at the following locations:

- (1) All locomotives.
- (2) Baggage and express cars (where employees are assigned for work en route).
- (3) Caboose.
- (4) Camp cars.
- (5) All terminals.
- (6) All yard offices.
- (7) All stations.
- (8) All freight, baggage, and express offices (located on railroad property).
- (9) All shops and engine houses.
- (10) All bunk or section houses and section headquarters.
- (11) All lunchrooms located on railroad property.
- (12) All permanent watchmen shelters at public highway crossings.
- (13) All maintenance-of-way camps.
- (14) All office work areas.

b. Reserved.

29.2(4) Washing facilities.

a. *General specifications—wash basins—lavatories.*

(1) Wash basins or lavatories will be made of vitrified glazed earthenware, vitreous enameled metal, or other smooth-finished material, impervious to moisture.

(2) Twenty-four inches of trough or circular wash basin will be considered the equivalent of one wash basin. The trough or circular wash basins will not be equipped with a plug or stopper.

(3) Spring-closing, hand-operated faucets are prohibited in trough wash sinks or circular basins.

b. *Wash basins—availability.*

(1) An adequate number of wash basins or lavatories for maintaining personal cleanliness will be provided within reasonable access for all employees normally assigned to work at the following locations: all terminals; all yard offices; all stations; all freight, baggage and express offices (located on

railroad property); all shops and engine houses; all lunchrooms located on railroad property; and at all bunk or section houses.

(2) One lavatory for every 10 employees or portion thereof, up to 100 persons; and over 100 persons, one lavatory for each additional 15 persons or portion thereof will be provided.

(3) At least one wash basin will be located in or adjacent to each toilet room.

c. Wash basins—supplies.

(1) Hot and cold running water will be supplied.

(2) Mechanical drying facilities or individual towels, either paper or cloth, will be provided.

(3) Waste receptacles will be provided for used paper towels.

(4) Soap or other suitable cleansing agent will be supplied at each wash basin.

29.2(5) *Showers, locker rooms, dressing rooms and lockers.*

a. Showers.

(1) Showers will be required when such facilities are necessary at specified locations to protect employees whose work involves exposure to poisonous, infectious or irritating material or to excessive dirt, heat fumes or vapors or other materials or substances injurious to health. Such shower facilities will be provided in conjunction with adequate and necessary locker or dressing room facilities.

(2) Showers will be connected to an ample supply and pressure of hot and cold water, preferably mixed.

(3) Each shower room or compartment will be constructed of material impervious to moisture.

(4) Each shower compartment will be not less than 36 inches in width and 36 inches in depth.

b. Lockers or dressing rooms.

(1) In all places of employment where, because of the nature of the work, it is necessary to change clothing, a locker room will be provided separated from toilet rooms by solid partitions and doors. Such locker rooms will have not less than 80 square feet of floor space per ten employees, or portion thereof, and for each additional employee, not less than 4 additional square feet will be added thereto. Necessary furniture, such as benches and tables, will be provided.

(2) Such locker or dressing rooms will be properly lighted, heated to a minimum of 65°F and adequately ventilated. Where practicable, cross-ventilation will be provided.

c. Lockers. In all places of employment where the nature of the employment requires a change of clothing, individual metal lockers will be provided. The dimensions of metal lockers will be not less than 12 inches wide, 18 inches deep and 72 inches high, exclusive of legs or other base. The lockers will be equipped with a shelf and with not less than one clothes hook for each side or equivalent hanger bar, and sufficient openings in the door for purposes of ventilation. Wooden lockers are prohibited.

d. Separate facilities for women.

(1) In instances where women or girls are employed in such activities, the showers, lockers and dressing rooms used by them will be separate and apart from those used by the men and boys.

(2) Such facilities will have separate entrances and exits and will be so marked.

875—29.3(88) Toilets—requirements.

29.3(1) *General.*

a. Where running water and sewer or septic tank connections are reasonably available, flush-type toilets and urinals will be maintained.

b. Chemical toilets or privies may be used where it is impractical to install inside toilet or urinal facilities.

c. No privy, urinal, cesspool, septic tank or other receptacle for human excrement will be constructed, maintained or used, except those maintained on moving equipment, which directly or indirectly drains or discharges over, into or upon the surface of the grounds, or into the waters of the state, either directly or indirectly, unless the contents of such urinal, cesspool, septic tank or receptacle for human excrement are subjected to some recognized sterilization treatment approved by the department of health and human services.

29.3(2) *Water closets.*

a. Every flush toilet will have a rim flush bowl or be so constructed as to prevent the accumulation of fecal matter on the bowl. The bowl will be constructed of smooth-finished material impervious to moisture.

b. Every such bowl will be so installed that the surroundings and floor space can be easily cleaned.

c. No pan, plunger or wash-out water closets are permitted, except that pan or double-pan types are permitted for running facilities.

d. Every flush toilet will have a separate hinged seat made of a material, other than metal, that does not absorb moisture or that will be finished with substances resistant to moisture.

29.3(3) Urinals.

a. Every urinal will be made of smooth-finished material impervious to moisture.

b. Every urinal will be located within a toilet room.

c. Twenty-four inches of trough urinal will be equivalent to an individual urinal.

d. Wherever a slab urinal is installed, the floor, for a distance of not less than 24 inches in front of the urinal, will be sloped toward the urinal drain with adequate splash guards.

e. Every urinal will be flushed from a water-supplied tank or through valve, and flush valves will be installed with an approved backflow preventer. Every such tank will furnish an adequate quantity of water for each discharge for every fixture. In place of such discharge from a tank or flush valve, water may be allowed to run continuously over slab or trough urinals.

f. Clear floor space allowed for each urinal or its equivalent will be not less than two feet in width; adequate passage will be allowed.

29.3(4) Chemical toilets. All chemical toilets installed will be of a type approved by the division of labor services. Containers will be charged with chemical solution of proper strength, and their contents will be agitated daily with proper devices provided for that purpose. When containers are more than two-thirds full, the contents will be disposed of in an approved manner, such as by burial or into a public sewer system. The stacks connecting the seats with the containers will be cleaned as often as is necessary to keep them in a clean and sanitary condition.

29.3(5) Incinerator toilets.

a. All incinerator toilets used on railroad equipment must be of a type approved by the division of labor services.

b. The installation and method of venting must be approved by the division of labor services.

c. Clear and concise instructions must be provided by the railroad company to ensure that the units are operated correctly.

29.3(6) Privies.

a. All privies will be located so as to avoid contaminating any water of the state.

b. A suitable approach, such as concrete, gravel or cinder walk, will be provided.

c. Privies will be constructed and maintained insect- and rodent-proof.

d. Every privy will be provided with a door, and such door will be self-closing.

e. The lids over the seats will be so constructed as to fall into a closed position when the seat is not occupied.

f. The pit or vault will be ventilated to the outside air by means of a stack protected at its outlet and by screens.

g. Individual seats will be provided in accordance with the ratio hereinafter set forth.

29.3(7) Toilet rooms—specifications for.

a. Separation.

(1) No toilet room will have direct communication with any room in which unwrapped food products are prepared, stored, handled or sold unless separated from said room by a self-closing door maintained in operating condition.

(2) Separate toilet facilities will be provided for each sex.

(3) There will be no direct connection between toilet rooms for men and women. Each will have a separate entrance, and each door leading thereto will have an automatic closing device maintained in operating condition.

- b. Compartments.* Each water closet in toilet rooms containing more than one water closet, or water closets, together with one or more urinals, will be in an individual compartment.
- c. Ventilation.* Every toilet room will be adequately ventilated.
- d. Lighting.* All toilet facilities will be well-lit during working hours.
- e. Heating.* Except privies, every toilet room will be kept adequately heated.
- f. Screens.* All windows, ventilators and other openings will be screened to prevent the entrance of insects. Toilet rooms will be kept free of insects and vermin.

29.3(8) Toilets—number required—general.

- a.* Adequate toilet facilities will be provided for all employees. Such facilities will be conveniently located and accessible and will be maintained in a usable and sanitary condition.
- b.* The following table will be used as a guide in determining the adequacy of toilet facilities.

Number of Employees	Minimum Number of Facilities
1 to 10 persons	1 toilet
11 to 24 persons	2 toilets
25 to 49 persons	3 toilets
50 to 74 persons	4 toilets
75 to 100 persons	5 toilets
Over 100	1 toilet for each additional 30 persons

- c.* Whenever urinals are provided, one urinal may be substituted for one toilet, provided the number of toilets will not be reduced to less than two-thirds of the number shown in the foregoing table.

29.3(9) Toilets—supplies.

- a. Toilet paper.* An adequate supply of toilet paper with holder will be supplied by the employer for each toilet.
- b. Sanitary napkins.* In all toilet rooms used by women, the company will permit the installation of dispensing machines for sanitary napkins.

29.3(10) Toilets—location of and type.

- a.* Appropriate toilets will be provided on the following facilities:
 - (1) All locomotives, except when used in yard service or as unmanned auxiliary units.
 - (2) Baggage and express cars where employees are required to work en route.
 - (3) Caboose.
 - (4) All terminals.
 - (5) All yard offices.
 - (6) All stations or depots.
 - (7) All freight, baggage and express offices (located on railroad property).
 - (8) All engine houses and shops.
 - (9) All bunk or section houses and section headquarters.
 - (10) Lunchrooms located on railroad property.
 - (11) All maintenance-of-way camps.
 - (12) Crossing watchman locations, where practicable, and where such facilities are not otherwise readily and conveniently located.
 - (13) All office work areas.

875—29.4(88) Eating places and lunchrooms—requirements.

29.4(1) Eating places.

- a.* Whenever practicable and at all permanent and semipermanent installations, an acceptable place, maintained in clean and sanitary condition, with adequate space for eating meals will be provided for employees who bring their meals to their place of employment or eat their meals prepared at the camp facilities.
- b.* Eating places will be so constructed as to permit their being readily cleaned, and they will be kept clean, in good repair and free of rodents, insects and vermin.
- c.* Kitchen cars or other camp facilities will have adequate equipment for the sanitary preparation, cooking and refrigeration of food.

29.4(2) Lunchrooms.

a. Concessionaire facilities provided by the company in lieu of direct company operation will comply with these rules with respect to adequate space, adequate food handling facilities and cleanliness.

b. Adequate table and seating facilities will be provided for the maximum number of employees using the room at any one time.

29.4(3) Lunchrooms and eating places—additional requirements.

a. *General.* The minimum area of lunchrooms, or the amount of space to be added to that required for a locker room where a lunchroom is not provided, will be based upon the maximum number of employees using the room or added space at any one time, generally in accordance with the following table:

Number of Employees	Square Feet Per Employee
25 and less	13
26 to 74	12
75 to 149	11
150 and over	10

b. *Ventilation.* Every eating place and lunchroom will be adequately ventilated. Where practicable, cross-ventilation will be provided.

c. *Lighting.* All lunchrooms will be clearly lighted at all times during hours of use.

d. *Heating.* Every lunchroom will be kept reasonably heated at all times.

e. *Screens.* The windows, ventilators and doors opening to the outside of all lunchrooms will be properly screened during the season when insects are prevalent.

f. *Waste disposal.* One or more covered receptacles, as may be necessary, will be furnished in lunchroom and eating places for the disposal of waste food and other waste matter. Such containers will be emptied regularly and cleaned as often as is necessary. The area where the receptacles are kept will be maintained free of litter occurring from the possible overflow of such receptacles.

875—29.5(88) Sleeping accommodations—requirements.

29.5(1) Running facilities. Camp cars, other than passenger coaches, furnished for sleeping purposes, will provide at least 50 square feet of floor space for each person with a ceiling height of not less than 7 feet. Where double bunks are used, at least 30 square feet of floor space will be provided for each person so accommodated. Where passenger coaches are furnished, the division of labor services may designate the number of persons to be housed in each coach.

a. Walls, floors and ceilings will be so constructed as to permit them to be readily cleaned.

b. Exterior windows and doors will be weather stripped during the cold weather.

c. Screens will be provided during the season when insects are prevalent for outer doors and windows.

d. Heating facilities and adequate fuel will be provided with which employees may maintain a comfortable temperature as weather conditions may require.

e. Lighting by windows or acceptable artificial illumination will be provided.

f. Ventilation will be provided by windows opening directly to the outside air.

g. Beds, bunks or cots with proper mattresses will be provided. Such beds, bunks or cots will be raised at least 12 inches above the floor and be located 2 feet or more from the side of any other bed, bunk or cot located in the same room and have at least 27 inches of clear space above it.

29.5(2) Stationary facilities.

a. Dormitories or bunk rooms will be of such area as to provide at least 50 square feet of floor area for each person. Where double bunks are used, at least 30 square feet of floor space will be provided for each person so accommodated. The headroom of dormitories or bunk rooms will be at least 7 feet.

b. Specifications for walls, floors and ceilings, lockers, drinking water, toilet accommodations, washing facilities, ventilation, lighting, heat, weather stripping, screening, beds, bunks or cots as described in running facilities of this rule will apply to stationary facilities.

875—29.6(88) Cleanliness and maintenance—requirements.**29.6(1) General specifications.**

a. The company will provide for the cleanliness and maintenance of the facilities, fixtures and appurtenances referred to in these regulations. Said fixtures will be maintained in proper working order when offered for use.

b. Toilet rooms and washrooms will not be used for storage.

29.6(2) Floors. Floors will be maintained in a clean and, so far as practicable, dry condition.

29.6(3) Screens. Screens required by these rules will be of 16 mesh or equal.

29.6(4) Receptacles for waste. Suitable receptacles will be provided and used for the storage of waste and refuse and will be maintained in a sanitary condition.

29.6(5) Yard servicing areas. Toilet waste will not be discharged onto the ground surface from railroad cars within servicing areas of yards. Such areas will be kept free of refuse, litter, debris, vermin and rodents.

29.6(6) Yard repair areas. Where work is performed in repair yards or on repair tracks in the open or in open sheds of pits, adequate drainage will be provided.

29.6(7) Running facilities.

a. Locomotives and yard diesels. During use, the cabs on locomotives will be heated to a minimum of 50°F at floor level.

(1) When required by the season of the year, doors and windows of all locomotives will be equipped with adequate protection to occupants from the elements by means of weather stripping or other device sufficient to provide equally adequate protection.

(2) Reserved.

b. Caboosees.

(1) Caboosees will be maintained in a clean and sanitary condition.

(2) When required by the season of the year, doors and windows of cabooses will be equipped with adequate weather stripping.

(3) Every caboose used in any train in this state, regardless of service, will be provided with a stove or other adequate means of heating. Caboosees will be heated to a minimum of 50°F at floor level.

c. Running facilities will be equipped with shatterproof glass.

29.6(8) Stationary facilities.

a. *Bed linen.* Where bed linen is furnished by the railroad, it will be changed and fresh clean linen supplied at least once a week or for each new occupant.

b. *Crossing watchmen facilities.* Adequate shelter will be furnished and maintained for crossing watchmen. Such shelter will be adequately heated, sealed and insulated against cold and inclement weather.

c. *Office work areas.*

(1) Office work areas will be maintained in clean condition.

(2) Office work areas will be clearly lighted at all times during hours of use.

(3) Office work areas will be heated at all times during hours of use at not less than 65°F.

(4) Office work areas will be provided with cross-ventilation when possible.

(5) Windows, ventilators and doors opening to the outside of office work areas will be properly screened during the seasons when insects are prevalent.

875—29.7(88) Conflicts resolved. In the event the rules in this chapter conflict or contain provisions inconsistent with the rules in 875—Chapter 10 or 875—Chapter 26, the applicable provisions of 875—Chapter 10 or 875—Chapter 26 prevail.

These rules are intended to implement Iowa Code section 88.5(11).

ARC 8245C**TRANSPORTATION DEPARTMENT[761]****Notice of Intended Action****Proposing rulemaking related to contested cases
and providing an opportunity for public comment**

The Transportation Department hereby proposes to rescind Chapter 13, “Contested Cases,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code chapter 17A and section 307.12(1)“j.”

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A and section 10A.801.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 13 in compliance with Executive Order 10. Proposed Chapter 13 explains the minimum procedural requirements for Department involvement in contested cases and informal settlements in accordance with Iowa Code chapter 17A. The intended benefit is to provide clarity and transparency on the process that aggrieved parties (including both individuals and entities) may use to dispute a decision of the Department. Another intended benefit is to provide consistency across the Department’s many bureaus that are a party or a facilitator of such dispute.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on June 12, 2024. A public hearing was held on the following date(s):

- July 8, 2024

The Department received no comments.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 8, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 7, 2024 10 to 10:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 573 926 021
November 8, 2024 11 to 11:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 526 404 95

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 13 and adopt the following **new** chapter in lieu thereof:

CHAPTER 13 CONTESTED CASES

761—13.1(17A) Definitions. The definitions in Iowa Code section 17A.2 are hereby adopted. In addition:

“*Department*” means the Iowa department of transportation.

“*Director*” means the director of transportation or the director’s designee.

761—13.2(17A) Applicability.

13.2(1) This chapter provides the minimum procedural requirements for department involvement in contested cases under Iowa Code chapter 17A.

13.2(2) Rules that apply to a particular type of contested case take precedence over this chapter. If there are no other rules applicable to a particular type of contested case, it will be conducted in accordance with this chapter.

761—13.3(17A) Submission of request for informal settlement or hearing.

13.3(1) A person who is aggrieved by an action of the department and who is entitled to a contested case hearing may:

- a. Unless prohibited by statute, request an informal settlement.
- b. Initiate a contested case by submitting a request for a contested case hearing.
- c. Use both procedures.

13.3(2) A request for an informal settlement or a contested case hearing shall be submitted in writing to the director of the bureau or division of the department that administers the matter at issue.

13.3(3) The request shall include complete names, mailing addresses to be used for communications with the department, and telephone numbers for all persons involved and any attorneys representing them.

13.3(4) A statute or rule may provide for submission of requests within a specified time period. A request shall be considered timely submitted if it is postmarked or delivered to the appropriate bureau or division of the department within the time period specified. Timely submission of a request shall be jurisdictional.

761—13.4(17A) Informal settlement.

13.4(1) An informal settlement may be handled by telephone.

13.4(2) If an informal settlement cannot be reached within a reasonable period of time, the department will notify the person in writing that there has been a failure to reach an informal settlement, that the department's action or decision is sustained, and that the person may request a contested case hearing.

761—13.5(17A) Contested case.

13.5(1) Procedures.

a. The department may initiate a contested case proceeding. Prior to initiating the contested case proceeding, the department, unless disallowed by statute, may attempt to settle the matter informally.

b. After a contested case hearing, a written decision will be issued by the presiding officer.

13.5(2) Hearing.

a. The department may be represented by legal assistants, paralegals, or designated attorney general staff at contested case hearings. Any such person is under the supervision of the attorney general transportation section chief.

b. The department may designate staff not under the supervision of the attorney general's office to appear at contested case hearings as witnesses. Staff so designated may appear to testify about matters including but not limited to clarifying the record, providing additional information, providing justification for the department's action, or answering questions of the appellants and presiding officer.

c. The department may submit certified copies of records admitted pursuant to Iowa Code section 321.10 in lieu of either legal representation or participation by a department employee.

13.5(3) Appeal of contested case decision.

a. A decision by a presiding officer shall become the final decision of the department and is binding on the department and the party whose legal rights, duties and privileges are being determined unless either appeals the decision as provided in this subrule.

b. No additional evidence is to be presented on appeal that is decided on the basis of the record made before the presiding officer in the contested case hearing.

c. The appeal is to include a statement of the specific issues presented for review and the precise ruling or relief requested.

d. An appeal of a presiding officer's decision is to be submitted in writing to the director of the bureau or division that administers the matter being contested. The appeal is deemed timely submitted if it is postmarked or delivered to the director of the appropriate bureau or division of the department within 20 days after the date of the presiding officer's decision unless otherwise provided in rule or statute.

e. The director of the administering bureau or division will forward the appeal to the director.

f. Failure to timely appeal a presiding officer's decision is considered a failure to exhaust administrative remedies.

g. The director may make a decision affirming, modifying or reversing the presiding officer's decision, or may remand the case to the presiding officer.

h. The decision of the director is the final decision of the department and constitutes final agency action for purposes of judicial review. No further steps are necessary to exhaust administrative remedies.

761—13.6(17A) Motion for review. The director may, on the director's own motion, review the presiding officer's decision. The motion for review is subject to the same time limits as an appeal from a presiding officer's decision. If there is a motion for review, paragraphs 13.5(3) "g" and "h" apply.

761—13.7(17A) Rehearings. An application for rehearing of a final decision under Iowa Code section 17A.16 shall be filed with the director.

761—13.8(17A) Maintenance of records. The department shall retain for at least five years from the date of the final decision copies of the record made before the presiding officer, the decision received from the presiding officer, the decision issued by the director, and related correspondence.

761—13.9(17A) Communications.

13.9(1) Each party to a contested case is to keep the department informed of the party's current address and telephone number; the name, address and telephone number of the party's attorney, if any; and the mailing address to be used for communications from the department.

13.9(2) Mailed notices, communications and decisions regarding the contested case are to be sent by first class or certified mail to the latest address that each party has provided to the department.

13.9(3) Notwithstanding subrule 13.9(2), the department of inspections, appeals, and licensing may communicate with the party or the party's attorney by email and may file and serve documents through the division of administrative hearings' administrative electronic management system.

761—13.10(17A) Default.

13.10(1) A party may move for default against another party that has requested the contested case proceeding and that has failed to appear after proper service is served.

13.10(2) Notwithstanding subrule 13.10(1), no default may be entered against the department for failure to appear; rather, the presiding officer may either continue the matter or proceed with the hearing and render a decision in the absence of the department.

13.10(3) A default decision or a decision rendered on the merits after a party has failed to appear or participate in a contested case proceeding becomes final agency action unless, within 20 days after the date of the decision, either a motion to vacate is filed and served on the presiding officer and the other parties or an appeal of a decision on the merits is timely submitted in accordance with rule 761—13.5(17A). A motion to vacate is to state all facts relied upon by the moving party that establish that good cause existed for that party's failure to appear or participate.

13.10(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

13.10(5) Timely filed motions to vacate are to be granted only for good cause shown. The burden of proof is on the moving party. Adverse parties have ten days to respond to a motion to vacate.

13.10(6) "Good cause," for the purpose of this rule, means surprise, excusable neglect or unavoidable casualty.

13.10(7) A decision denying a motion to vacate is subject to further appeal in accordance with rule 761—13.5(17A).

13.10(8) A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party in accordance with subrule 13.5(3).

13.10(9) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer is to issue another notice of hearing and the contested case will proceed accordingly.

761—13.11(17A) Additional procedures when the department is not a party.

13.11(1) *Jurisdiction.* When the department is obligated by statute to administer a controversy to which it is not a party, the following additional procedures apply.

13.11(2) *Request.*

a. A person who has an interest in a controversy and who is entitled to a contested case hearing may submit a written request to the department to resolve the controversy.

b. An acceptable request will contain a statement of facts alleged and the relief sought by the requestor, the name and address of the persons involved and any attorneys representing them, the requestor's telephone number, and the mailing address to be used for all communications to the requestor from the department.

13.11(3) *Informal settlement.*

a. The department will contact the persons involved, either by telephone or letter, and will offer to assist the parties to reach an informal settlement of the controversy.

b. A controversy may be settled informally by the persons involved.

c. When a controversy is settled informally, the persons involved will each notify the department by telephone and confirming letter that the controversy has been resolved.

13.11(4) *Contested case.* When the department is notified by a person involved in the controversy that there has been a failure to reach an informal settlement, or when the department determines that no progress toward a settlement is being made, the department will send a written notice to the persons involved specifying that if the department is not notified of a settlement within 20 days after the notice is mailed, the department will initiate a contested case proceeding.

These rules are intended to implement Iowa Code chapter 17A and section 10A.801.

ARC 8246C

TRANSPORTATION DEPARTMENT[761]

Notice of Intended Action

**Proposing rulemaking related to holiday rest stops
and providing an opportunity for public comment**

The Transportation Department hereby proposes to rescind Chapter 105, "Holiday Rest Stops," Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 307.12(1)"j" and 314.27.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 314.27.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 105 in compliance with Executive Order 10. Proposed Chapter 105 provides nonprofit organizations an opportunity to promote their products at Iowa rest areas during holiday periods in compliance with Iowa Code section 314.27.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on May 1, 2024. A public hearing was held on the following date(s):

- May 28, 2024

The Department received no comments.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 7, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 6, 2024 11 to 11:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 459 079 854
November 7, 2024 2 to 2:30 p.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 722 926 003

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 105 and adopt the following **new** chapter in lieu thereof:

CHAPTER 105
HOLIDAY REST STOPS

761—105.1(314) Purpose. The purpose of this chapter is to establish the requirements and procedures for approving requests for rest stops on primary and interstate highways during holiday periods.

761—105.2(314) General.

105.2(1) Definitions.

“Free refreshments” means the same as defined in Iowa Code section 314.27.

“Holiday periods” means the same as defined in Iowa Code section 314.27.

“Holiday rest stop” means a location where a sponsor serves free refreshments to motorists during holiday periods to provide a break from driving monotony, promote safer driving, and reduce the potential for highway accidents.

“Sponsor” means the nonprofit organization that is providing the free refreshments and staffing the holiday rest stop.

105.2(2) Information. Information regarding this chapter is available from the Maintenance Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010, or the department’s website at www.iowadot.gov.

761—105.3(314) Conditions. The sponsor of a holiday rest stop shall comply with the following general conditions:

105.3(1) Not request or accept payment for the refreshments served. The sponsor may accept voluntary donations using containers clearly labeled with a sign stating “donations.” If the sponsor uses donation containers, the sponsor needs to place signs within the immediate area of the operation at locations designated by the department stating “free refreshments.”

105.3(2) Not distribute any literature or other promotional material.

105.3(3) Clean up the area and remove all signs the sponsor has erected promptly after the holiday rest stop is discontinued.

105.3(4) No permit parking on the highway shoulders.

105.3(5) Agree to indemnify, defend and hold the department of transportation and the state of Iowa harmless from any liability that may result from the directing of traffic to the holiday rest stop area, and as a result of changes of traffic patterns caused by the activities of the sponsor in or about the holiday rest stop area, and all other liability related to the operation of the special holiday rest stop and the refreshments provided.

761—105.4(314) Holiday rest stops.

105.4(1) Site.

a. A holiday rest stop along an interstate highway shall be in an established interstate rest area. Running water is available at each rest area. The department will provide electricity if requested.

b. The proposed site of a holiday rest stop along a primary highway will be inspected by the department to ensure it meets the following requirements:

(1) The site is large enough to provide parking space for at least 15 vehicles and located so that all parked vehicles will be at least 50 feet from the edge of the traveled way of the primary highway.

(2) An access drive from the primary highway shoulder to the parking area has a top width of at least 20 feet and provides a clear view of the primary highway for at least 900 feet in each direction.

c. The department will designate an appropriate spot within the requested holiday rest stop location that will not include rest area restroom buildings or welcome center buildings. The sponsor may use the information kiosk where available. A tent or canopy may be used in areas without a kiosk during inclement weather.

105.4(2) Signs. The sponsor shall:

a. Not place any signs directing highway traffic to the holiday rest stop.

b. Not place any signs for an interstate holiday rest stop along the interstate highway or interchange ramps. The department will place signs stating “free refreshments” adjacent to the interstate highway and will remove these signs when the holiday rest stop is discontinued.

c. Provide two signs approximately four feet by four feet announcing the holiday rest stop, one for each highway approach to the site for holiday rest stops on primary highways. The department will install these signs and will remove them when the holiday rest stop is discontinued.

d. Take responsibility for any signs posted at the actual holiday rest stop site. Signs provided or placed by the sponsor shall not include any advertising but may include the sponsor’s name. Signs shall not be mounted on objects (including vehicles) that contain the name of any organization or individual except the sponsor. The sponsor is responsible for the removal of all signs the sponsor has erected promptly after the holiday rest stop is discontinued.

105.4(3) Request.

a. A request to sponsor a holiday rest stop will be made on Form 810023. This form is available from the maintenance bureau or the department's website.

b. The request will include the name and address of the requesting sponsor, a detailed description of the proposed holiday rest stop location, and the requested hours of operation.

c. The request will be submitted to the maintenance bureau and must be submitted at least 90 days prior to the beginning date of the holiday period and may be accepted up to 12 months in advance.

105.4(4) Approval of request.

a. The maintenance bureau will notify the potential sponsor of approval or disapproval of the request within the time frame specified in Iowa Code section 314.27.

b. If there is more than one qualifying request for the same site and date, the sponsor will be selected by lottery.

These rules are intended to implement Iowa Code section 314.27.

ARC 8250C**TRANSPORTATION DEPARTMENT[761]****Notice of Intended Action****Proposing rulemaking related to real property acquisition and relocation assistance and providing an opportunity for public comment**

The Transportation Department hereby proposes to rescind Chapter 111, "Real Property Acquisition and Relocation Assistance," Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 307.12(1)"j" and 316.9.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 316 and sections 6B.42, 6B.45, 6B.54, 6B.55 and 310.22.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 111 in compliance with Executive Order 10. Proposed Chapter 111 complies with Iowa Code section 316.9 to ensure compliance with the federal Uniform Relocation Assistance and Real Property Acquisition Policies Act (Uniform Act). To comply with this federal act, the Department adopts by reference Section II of the manual entitled "Uniform Manual, Real Property Acquisition and Relocation Assistance." This manual, which is published by the Department and is available on its website, is based on federal regulations, 49 CFR Part 24, which implement the Uniform Act.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on April 17, 2024. A public hearing was held on the following date(s):

- May 9, 2024

The Department received no comments.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 8, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 7, 2024 11 to 11:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 484 679 961
November 8, 2024 9 to 9:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 887 511 409

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 111 and adopt the following **new** chapter in lieu thereof:

CHAPTER 111

REAL PROPERTY ACQUISITION AND RELOCATION ASSISTANCE

761—111.1(316) Acquisition and relocation assistance manual. The September 2017 edition of Section II of the manual entitled “Uniform Manual, Real Property Acquisition and Relocation Assistance” is adopted by reference.

111.1(1) Contents. Section II establishes uniform rules and procedures that comply with Iowa law and the Federal Uniform Relocation Act for the acquisition of real property and for the provision of relocation assistance to persons who are displaced from real property as a result of programs and projects. Relocation assistance is not compensation for real property acquired nor is it compensation for damages to remaining property. Rather, relocation assistance is assistance and compensation provided to a displaced person for making the move and relocating.

111.1(2) Applicability.

a. In general, Section II applies to any program or project that involves the acquisition of real property or that causes a person to be a displaced person if the program or project:

- (1) Is undertaken with federal financial assistance, or
- (2) Is a road or street program or project undertaken with state financial assistance from the primary road fund, including primary road funds allocated for state park and institutional roads, or
- (3) Is a public road or highway eligible for federal aid.

b. In general, Section II applies to any of the following entities that acquire real property or displace a person for a program or project described in paragraph 111.1(2)“*a*”:

- (1) The state of Iowa.
- (2) A political subdivision of the state.
- (3) A department, agency or instrumentality of one or more states or political subdivisions.
- (4) A utility or railroad subject to Iowa Code section 327C.2 or chapter 476, 478, 479, 479A or 479B authorized by law to acquire property by eminent domain.
- (5) Any other person who has the authority to acquire property by eminent domain under state law.
- (6) Any other person who acquires real property or displaces a person for a program or project described in paragraph 111.1(2)“*a*.”

c. Any exceptions to paragraphs 111.1(2)“*a*” and “*b*” are set out in Section II.

d. In accordance with Iowa Code section 316.9(3), an entity that provides relocation assistance benefits for any program or project is to provide an appeal process, regardless of the source of funding for the program or project. The appeal process provided is not to diminish the rights of the appellant or the scope of the appeal as described in Section II.

111.1(3) Availability of manual. Copies of the manual are available from the Right of Way Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or on the department’s website at www.iowadot.gov/rightofway/brochures-and-manuals.

111.1(4) Future programs or projects. Failure to comply with Section II when acquiring real property or displacing persons for a program or project may preclude the receipt of future federal financial assistance for the program or project area.

This rule is intended to implement Iowa Code chapter 316 and sections 6B.42, 6B.45, 6B.54, 6B.55 and 310.22.

ARC 8251C

TRANSPORTATION DEPARTMENT[761]

Notice of Intended Action

**Proposing rulemaking related to primary highway access control
and providing an opportunity for public comment**

The Transportation Department hereby proposes to rescind Chapter 112, “Primary Highway Access Control,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 307.12(1)“j.”

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 17A and sections 306.19, 306A.1 through 306A.8, 307.12(1)“j,” 318.3, 318.5 and 318.8.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 112 in compliance with Executive Order 10. Proposed Chapter 112 controls access for all primary highways for efficient and safe highway operations and to utilize the full potential of the highway investment. Effective controlled access on all primary highways protects the safety and welfare of the traveling public.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on May 1, 2024. A public hearing was held on the following date(s):

- May 23, 2024

The Department received no comments.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 7, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 7, 2024
9 to 9:30 a.m.

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 964 658 700

November 7, 2024
1 to 1:30 p.m.

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 953 446 154

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 112 and adopt the following **new** chapter in lieu thereof:

CHAPTER 112
PRIMARY HIGHWAY ACCESS CONTROL

761—112.1(306A,318) Scope and contact information.

112.1(1) *Statement of policy.* All primary highways are controlled access facilities. The efficiency and safety of a highway depend to a large extent upon the amount and character of interruptions to the movement of traffic. The primary cause of these interruptions is vehicular movement to and from public roadways, businesses, residences, and other developments along the highway. Regulation and overall control of highway access are necessary to provide efficient and safe highway operation and to utilize the full potential of the highway investment. Each highway access connection should be located and designed to achieve the least adverse impact to traffic operations and public safety. Accordingly, the department hereby establishes rules for control of access for all primary highways.

112.1(2) *Contact information.* Information regarding this chapter may be obtained from the department's website at: www.iowadot.gov/traffic/Access-Management/Access-Management-Resources; any of the department's six district offices; or the Traffic and Safety Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

761—112.2(306A,321) Definitions. As used in this chapter:

"Access" means a way or means of egress from or ingress to a highway.

"Access connection" means any point of motor vehicle ingress to or egress from a highway. It is the physical connection between the edge of the traveled way and the abutting property and is exclusive of the roadway and median.

"Average annual daily traffic" or *"AADT"* means the total volume of traffic passing a point or segment of a highway facility in both directions for one year divided by the number of days in the year.

"Functional area" includes any area upstream or downstream of an intersection where intersection operation and conflicts significantly influence driver behavior and vehicle operations. The functional area of an intersection is a calculated value based on the intersection's geometrics, posted speed limit, traffic volume, type of traffic control used and perception-reaction-time values determined by the American Association of State Highway and Transportation Officials.

"Highway" means the same as "street" or "highway" as defined in Iowa Code section 321.1(78).

"Intersection" means the same as defined in Iowa Code section 321.1(33).

"Necessity" means the access is required or indispensable to the property because of circumstances that cannot be sufficiently mitigated by other means. Proof of necessity refers to documents, data, maps and other information submitted to illustrate and verify the claim of necessity.

"Primary highway" means a highway that is under department jurisdiction.

"Ramp" means a special lane, usually a short section of one-way roadway, that provides an access connection between two roads to enter or exit a major highway. The term "ramp" includes but is not limited to entrance ramps, roadway ramps, loop roads and collector-distributor roads.

“*Roadway*” means the same as defined in Iowa Code section 321.1(65). A divided highway has two or more roadways.

“*Traveled way*” means the portion of a roadway used for the through movement of vehicles, excluding shoulders, gutters and auxiliary turn lanes.

“*Trip*” means a single or one-directional vehicle movement. A vehicle leaving the highway and entering a property is one trip, and the vehicle leaving the property and entering the highway is a second trip.

761—112.3(306A) General provisions. The following provisions govern access encroachments onto a primary highway:

112.3(1) Access connection construction activity on a highway shall not begin until an access permit has been issued by the department.

112.3(2) A new access permit is required when there will be a change in use of the access connection. A change in access use includes but is not limited to:

- a. A change in the predominant vehicle types using the access.
- b. An increase in traffic volumes using the access.
- c. The original design and engineering limitations have been exceeded by the current use.
- d. The current use has not been authorized by the terms and conditions of the existing access permit.

112.3(3) A person shall not drive a motor vehicle to or from a highway at a location that is not an authorized access connection.

112.3(4) Access rights shall not accrue from, nor will additional access be provided upon, the splitting or dividing of existing parcels of land or contiguous parcels under the same ownership or controlling interest unless the proposed access complies with access category and design requirements and is permitted. Adjacent properties under common ownership or control, consolidated for development, or part of a phased development plan are considered one unit, and a unified access and circulation plan must be established for the site.

112.3(5) No rights of access are conveyed when the department provides a new access connection or modifies an existing access connection.

112.3(6) The terms and conditions of any permit are binding upon the applicant, the property owner and all assigns, successors-in-interest, heirs and occupants. If an assign, successor-in-interest, heir or occupant does not accept the terms and conditions of an existing permit, the assign, successor-in-interest, heir or occupant shall apply for a new access permit or a permit to close the access.

112.3(7) A property owner not wanting to assume responsibility for an access or the access’s requirements may apply for access removal at the property owner’s expense. An exception may be made for removals during highway projects.

112.3(8) A permit grants no property rights or interests in state right-of-way.

112.3(9) Where there are multiple accesses to the same parcel, the department may consolidate existing access connections during a highway project.

112.3(10) The department has the authority regarding operational modifications to the highway and all access connections.

761—112.4(17A,306A,318) Permitting process. An access permit is required for an encroachment onto a public right-of-way for the construction, reconstruction or modification of an access connection or any of its related appurtenances.

112.4(1) *Application for an access permit.*

a. To obtain an access permit, applicants will use the web-based system found at eps.iowadot.gov. If the applicant cannot use or connect to this electronic system, the applicant may contact the appropriate district office that is responsible for the area in which the proposed access is located. An applicant may be the property owner or the owner’s authorized agent.

b. A separate access application and permit are required for each access connection.

c. Intentional misrepresentation of existing or future conditions or providing false information is considered sufficient grounds for denial or revocation of a permit.

d. The applicant is responsible for providing any location and design plans that describe the access.

e. The applicant is responsible for providing an estimate of the traffic volume of the access and the property as a whole. The estimate will include the anticipated average daily or hourly use and the anticipated access use upon the full development of the property.

f. For access types A and B as defined in subrule 112.5(2) and public intersections, the department requires a traffic impact analysis from the applicant during the processing of a permit request, except when the appropriate district engineer determines an analysis is not necessary. Such traffic impact analysis must be prepared by a professional engineer licensed in Iowa and at the cost of the applicant. The analysis will address a current and 20-year projection of traffic activity and impacts at and near the proposed access connection, including the full-development traffic volumes of the access connection.

g. It is the responsibility of the applicant to comply with all local ordinances and any other regulations.

112.4(2) *Processing an access application.*

a. Upon receipt of an application, the department will begin processing the application using the electronic permitting system. The department will apply the criteria as required by this chapter, including access type, access category, location, design, public safety and traffic operations.

b. The department may issue an access permit with terms and conditions or deny the application if it fails to meet this chapter's requirements. The department representative will notify the applicant of the determination.

c. The department will not act on an application it deems incomplete and will notify the applicant of additional information needed to complete the request.

d. Upon mutual agreement by the department and applicant, the department may suspend or extend the process period.

e. The applicant may withdraw the application.

112.4(3) *Permit terms and conditions.*

a. An access permit will include terms and conditions necessary to meet the requirements of this chapter and include consideration of the following:

- (1) Safety of the traveling public.
- (2) The access category pursuant to rule 761—112.5(306A).
- (3) The access location and design pursuant to rule 761—112.6(306A).
- (4) The traffic-carrying capacity of the highway.
- (5) Protection of the public investment in the highway.
- (6) Topography and geometric limitations and constraints.

b. The department may restrict turning movements as necessary to reduce adverse impacts. The department will consider the 20-year projection of traffic volumes on the roadway and the full-development traffic volumes of the access connection.

c. Access permits expire after one year if construction of the access is not initiated and no extension of time has been requested and granted by the department.

d. The property owner and the owner's authorized agent agree by accepting the permit to indemnify, defend and hold harmless the state of Iowa and its employees from all claims arising out of construction or use of the access.

e. The property owner and applicant assume liability for the construction and ongoing use of the access.

f. The permittee shall maintain the access in good repair at all times.

g. If the department has not received the signed copy of the permit within 60 days of the date of transmittal to the applicant, the permit is deemed withdrawn.

112.4(4) *Permits where department owns access rights.*

a. This subrule applies only where the department has determined there is no longer the necessity for the controlled access line at the proposed location. The department may issue an access permit if all design and location criteria are met.

b. If it becomes necessary to close the access, the property owner will be notified in advance and any permit will be revoked. The access application and permitting process do not include any rights of appeal where the department is the owner of the access rights.

112.4(5) Appeals.

a. An applicant or permittee who objects to any terms or conditions placed on an access permit, the denial of a permit, or the closure or revocation of an access may appeal the department's decision. If the department owns the access rights, this subrule does not apply.

(1) The appeal shall be submitted to the appropriate district engineer at the department.

(2) An appeal concerning the closure or revocation of an access or the denial of a permit must be submitted within 60 days of receipt of the department's notification.

(3) An appeal concerning the terms or conditions placed on an access permit must be submitted within 60 days of when the department sends the applicant the signed copy of the permit with terms or conditions for signature.

(4) The appeal must include reasons for the request and may include changes, revisions or conditions that would be acceptable to the applicant or permittee.

b. The district engineer will issue a written decision to the applicant or permittee within 60 days of receipt of the appeal or within 60 days after receipt of requested additional information.

c. Upon receipt of the written decision, the applicant or permittee may appeal the district engineer's decision by submitting the appeal along with background information to the director of transportation. The director will issue a written decision within 60 days of receipt of the appeal. The director's decision is final agency action.

112.4(6) Waivers. The director of transportation may, in response to a written petition, waive provisions of this chapter in accordance with 761—Chapter 11. The written petition must contain the information as required in 761—subrule 11.5(2) and shall be submitted to the rules administrator, either by mail to Rules Administrator, Government and Community Relations, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or by email to the rules administrator's email address listed on the department's website at iowadot.gov/administrativerules.

112.4(7) Waivers involving interstate highways. The director of transportation shall not waive these rules in access situations involving the interstate highway system, including its ramps, without the approval of the Federal Highway Administration.

761—112.5(306A) Access types and the primary highway category system. This rule manages access connections according to highway function, design, traffic volumes, speed and roadside conditions.

112.5(1) General.

a. The department will assign access categories to all highways according to the descriptions in subrule 112.5(3).

b. There are no minimum or maximum distance criteria for the length of a category assignment.

c. The department may assign a specific category to a segment of highway based on operational needs and to maintain consistency along a specific route.

d. The department will maintain an access category assignment schedule for the highway system.

e. Municipal access categories are for primary highway extensions within municipalities where concurrent jurisdiction applies pursuant to Iowa Code section 306.4(4).

f. For all access categories, access connections should be kept to the minimum necessary to provide reasonable access. A second access to a parcel may be provided only if it meets spacing criteria, internal circulation is not feasible, and there is a necessity for the access.

g. If the category allows type D access, an additional type D access may be granted to a parcel if the necessity due to topography problems or ongoing agricultural activities is demonstrated. A change in use of the parcel of land serviced by the type D access requires a new permit and may result in closure of the access if the location will not meet access category requirements for another type.

h. A secondary access for emergency fire services needed to meet local fire safety regulations may be permitted on all categories except for the categories interstate and freeway (I/F), expressway (E), and municipal expressway (ME) and across controlled access lines. Such emergency access may be permitted only if it is not feasible to provide the emergency access to a secondary roadway. A written explanation with references to local standards from an appropriate government safety official must be included with the application. The access shall be maintained by the permittee as a closed access except during emergencies. Hidden pavement structures are acceptable.

i. Access connections to government parcels will be treated the same as private access types based on volume with the exception of egress access connections used specifically for emergency response services such as fire stations.

112.5(2) *Access types.* Access connections are distinguished by the following four types of private access based on access connection traffic volume:

a. Type A is a private access connection with traffic volumes equal to or greater than 100 trips in a peak hour. Traffic volume estimates are to be based on a 20-year projection or the build-out of the development, whichever is greater.

b. Type B is a private access connection with traffic volumes between 11 and 99 trips in a peak hour. Traffic volume estimates are to be based on a 20-year projection or the build-out of the development, whichever is greater.

c. Type C is a private access connection with traffic volumes between one and ten trips in a peak hour.

d. Type D is a private access connection with an AADT of less than one per day.

112.5(3) *Access categories for highways.* Access categories are distinguished as follows:

a. The interstate and freeway (I/F) category applies to highways with full access control. Access to the roadway, when allowed, shall be provided by ramps. Direct access to the main roadway and all ramps is prohibited.

b. The expressway (E) category applies to nonfreeway multilane highways outside municipal boundaries where the department has acquired the associated access rights. Access that has not already been authorized shall not be permitted across existing access control lines. An access management plan is required to authorize a new public intersection. New direct access connections will not be permitted for utilities that have not been previously authorized.

c. The rural-600 (R-600) category applies to two-lane and multilane highways outside municipal boundaries that are on the Iowa commercial industrial network as most recently approved by the commission or are where roadway traffic volume will be equal to or greater than 3,000 AADT within 20 years. Access types A, B and C may be permitted where the applicant can prove necessity and the access has a minimum spacing distance of 600 feet from other connections. Access type D must meet sight distance requirements. Private access connections should not be permitted within the functional area of any public intersection. Public intersections should be located at survey section lines when feasible. Each full-movement access connection should serve as many properties and interests as possible to reduce the need for additional direct access to the highway.

d. The rural safety and need (R-S/N) category applies to two-lane highways outside municipal boundaries that will not exceed 3,000 AADT within 20 years. This category includes frontage roads, service roads and access ways. All private access types may be permitted where the applicant can prove necessity and meet sight distance requirements. Private access connections should not be permitted within the functional area of any public intersection. Public intersections should be located at land survey section lines when feasible.

e. The municipal expressway (ME) category applies to nonfreeway multilane highways inside municipal boundaries where arterial performance is necessary to provide high mobility and through traffic capacity. In the absence of an access management plan, private access shall not be permitted that has not already been authorized. An access management plan is required to authorize a new public intersection and may only be allowed if the public roadway is adopted by the city.

f. The municipal-1000 (M-1000) category applies to important regional and intracity highways that are within a municipality. Designation of M-1000 must include consideration of system continuity

and preservation of a high level of mobility and through traffic capacity. The department recommends the installation of restrictive medians between full-movement intersections. Access to an M-1000 may be granted under the following conditions:

(1) All access types are eligible for a full-movement access connection at 1,320 feet (one-quarter mile) locations based on section lines where feasible, and these access connections may be restricted to right-in and right-out turns or directional left-in-only as access volumes increase. If there is a documented necessity to permit access connections at locations less than 1,320 feet, then a minimum access spacing interval of 1,000 feet may be used. No access connection should be allowed within the functional area of a public intersection.

(2) Each full-movement location should serve as many properties and interests as possible to reduce the need for additional direct access to the highway.

(3) All access types are eligible for limited movement connections at minimum spacing intervals of 600 feet if a restrictive median is present.

g. The municipal-600 (M-600) category applies to highways within municipalities that have been determined to have a need to maintain a moderate level of mobility and through traffic capacity. Minimum spacing for all access types is 600 feet.

h. The municipal-300 (M-300) category applies to highways within municipalities where a low level of mobility and through traffic capacity is acceptable. Minimum spacing for all access types is 300 feet.

i. The municipal safety and need (M-S/N) category applies to highways within municipalities where motor vehicle mobility and through traffic capacity are low priorities. The permitting of access and the determination of access connection locations is based only on safety and need.

112.5(4) Category revisions.

a. From time to time, it may be necessary for the department to change an assigned access category because of changes in roadway conditions, traffic growth or highway reconstruction. Reassignment must be consistent with subrule 112.5(3). A report will be prepared presenting why the current category should not be used and the reasons for and benefits of making the category revision.

b. If the highway is identified as a future freeway or expressway, the department may suspend the issuance of new access permits.

c. If a highway utilizing at-grade intersections is intended to be improved to accommodate traffic growth or safety considerations, the access category of the future improvement will be applied.

112.5(5) Interchange and intersection access control.

a. When it is necessary for an at-grade access connection to be near an interchange on an access category E or ME, the first access connection location will be determined by calculating the functional areas of the expressway ramp and the first at-grade access connection. The two functional areas shall not overlap. The functional area of the ramp shall be considered no less than 1,500 feet from the end of the taper. The first access should be a public intersection. Access turning movements may be restricted for operational reasons.

b. Access is prohibited to all elevated structures and ramps on or connected to any highway.

c. When the interchange crossroad AADT will exceed 10,000 in the twentieth year, the first full-movement access connection should be at least 1,320 feet as measured from the ramp bifurcation point. A minimum of 1,000 feet may be allowed for a full-movement intersection if there is a proven necessity and no reasonable alternative. A restrictive median may be required between the ramps and the full-movement intersection. If the first full-movement intersection is at least 1,200 feet from the ramp bifurcation and a restrictive median is present, a right-in and right-out access may be permitted at a minimum of 600 feet from the ramp bifurcation. The ramp functional area should not overlap with the functional area of any access connection.

d. When the interchange crossroad AADT will be between 3,000 and 10,000 within 20 years, the first full movement should be at least 1,000 feet away from the ramp. All access types may have a restricted right-in and right-out access at a minimum of 600 feet from the ramp bifurcation point.

e. When the interchange crossroad AADT will not exceed 3,000 within 20 years, access public intersections and private access types A and B should be at least 600 feet away from the ramp

bifurcation point. Types C and D should be at least 300 feet from the bifurcation point and may be subject to operational restrictions.

f. For any new interchange or interchange reconstruction, access rights should be acquired and extend a minimum of 600 feet away from the ramp bifurcation point. If the AADT will exceed 10,000 within 20 years, a minimum of 1,000 feet of access rights should be acquired.

g. Where a free-flow turning movement from a roadway or ramp merges onto another roadway, an analysis is to be completed to determine the functional area and the preferred placement of the first access connection. The functional area of the merge lane of the roadway and the functional area of the first access connection should not overlap. Access rights are to be acquired along the identified functional area length.

h. An at-grade intersection is defined by the determination of its functional area. Access should not be allowed within this functional area. Access beyond the functional area remains subject to the requirements of the access category location standards.

i. When acquiring access rights as part of a highway project, the department may acquire access rights along intersecting public roadways to protect the operation of the intersection at the highway. Acquisition of access rights should extend a distance of 150 feet from the near edge of the highway traveled way. If the intersecting public roadway AADT is predicted to exceed 3,000 within 20 years, the department should acquire access rights for a distance of 300 feet from the near edge of the highway traveled way. The department may lengthen or shorten the distance of access rights required after considering the intersection functional area, traffic volumes, traffic operations, acquisition costs and other factors.

112.5(6) *Access management plans and agreements.*

a. Access management plans may be developed to determine how access will be managed on select sections of high-priority corridors, around freeway interchanges, and within municipalities and high-growth corridors. Each plan will apply access management techniques, identify acceptable traffic control features, and establish the necessary operational restrictions to ensure the long-term functional performance and safety of the highway. The scope of each access plan may vary depending on what is determined necessary by the parties of the agreement to manage current and predicted future highway conditions and local land use.

b. To apply an access management plan within a municipality, it must be adopted by joint agreement in accordance with Iowa Code sections 306.4(4) and 306A.7.

c. Highway projects and corridor plans may include access management techniques and improvements to bring a section of highway into conformance with its current access category without adopting an access management plan and agreement.

761—112.6(306A) Location and design. This rule sets criteria for the location and design of access connections to primary highways.

112.6(1) Each access connection authorized must be located and designed in accordance with this rule. Terms and conditions for location, design, construction and use of the access connection shall be established by permit.

112.6(2) The priority of the primary highway system is to provide highway corridors with the goal of maintaining traffic capacity by limiting disruptions to through traffic. Direct access from abutting land is therefore subordinate. Where an adjacent lower traffic volume road is available, the access should connect to that roadway.

112.6(3) Private access connections may only be considered when there is a reasonable necessity for the access and should be separated from other private access connections at a minimum distance equal to the sight distance at the posted speed. The burden of proving necessity is on the applicant.

112.6(4) An access connection must be consistent with the requirements of the assigned access category.

112.6(5) Access location considerations must include traffic operations, public safety, sight distance, distance to other access locations, traffic speed and volumes, the design vehicle for the access, and turning movements.

112.6(6) Restrictive medians may be installed and access connection turning movements may be restricted to right turns or directional left turns for operational reasons when determined necessary and at the sole discretion of the department.

112.6(7) Minimum design criteria may be used only when there is a proven and documented necessity that higher standards are not feasible at the specific site.

112.6(8) When there are access connections on opposite sides of the highway and left turns are allowed from both directions, the access connections should be opposite each other or have sufficient offset distance so as to prevent overlapping left turn maneuvers.

112.6(9) If the access connection requires a turn lane, the access connection should be located so the turn lane can be installed and no other access connections occur along the turn lane. An access should not be installed along a turn lane or taper.

112.6(10) Private access connections should not be located within the functional area of a public intersection.

112.6(11) All access connections must meet sight distance.

112.6(12) The access must be designed to facilitate the movement of vehicles from the highway to prevent the queuing of vehicles on the roadway.

112.6(13) If a proposed access location does not comply with this chapter, the access permit shall be denied.

112.6(14) If the department determines that the literal application of these rules to a specific situation will create or result in an unsafe situation or an unreasonable design, the department will use sound engineering practices to determine the appropriate location and design for the specific situation. The department will include justification for the design in the permit or the highway project file, as applicable.

761—112.7(306A) Access construction. This rule sets criteria for the construction of access connections.

112.7(1) Overall stipulations.

a. Unless part of a public construction project, the construction of the access and its appurtenances as stated in the terms and conditions of the permit shall be completed at the expense of the permittee.

b. The access connection must be constructed according to the department's standards and specifications. The applicant will be provided with the necessary standards and specifications with the issued permit.

c. The access shall be completed in an expeditious and safe manner and must be finished within 30 days from initiation of construction within the highway right-of-way unless otherwise stated on the access permit.

d. The department may restrict work within the highway right-of-way, restrict lane closure periods and require preapproval of all aspects of construction phasing and traffic control. The permittee shall provide work zone traffic control at all times during access construction. Work in the highway right-of-way is not allowed on legal holidays, at night, during peak traffic hours or during adverse weather conditions without specific department permission.

e. Any damage to the primary highway, appurtenances or any utility or any permitted private encroachment shall be repaired immediately at the direction of the affected owner. All costs associated with repair or relocation are to be borne by the permittee. If a survey monument is modified or damaged, repair and replacement shall be done at the direction of the owner of the monument.

f. The relocation, removal or modification of any traffic control device or public or private utilities shall be accomplished by the permittee without cost to the department or utility and at the direction of the department or utility owner.

g. An access permit may require installation of traffic control features or devices, but such requirements do not create any type of private interest in such features. Traffic control features and devices in the right-of-way, such as traffic signals, channelizing islands, medians, median openings, and turn lanes, are operational and safety characteristics of the highway and are not means of private access.

The department may install, remove or modify any traffic control feature or device in the right-of-way to promote traffic safety or efficient traffic operations.

h. The department is not obligated to permit or approve any connection, traffic control feature or device or any other site-related improvement that has been specified in a development approval process separate from the permitting criteria and approval process described in this chapter.

i. If any construction element of the permitted access fails within three years following construction, the permittee shall be responsible for all repairs. Failure to make such repairs may result in suspension of the permit and closure of the access.

j. The property owner or occupants are responsible for maintaining the access. Where the access connection has a paved surface, the property owner or occupants are responsible for maintaining the access connection from the paved edge of the roadway to the right-of-way line. Where the access connection does not have a paved surface, the property owner or occupants are responsible for maintaining the access from the outer shoulder line of the roadway to the right-of-way line. The department is not responsible for the removal of debris, snow or ice on the access, including debris deposited by the department during maintenance operations.

k. Drainage structures located along the highway are maintained by the department except for concrete box culverts and bridges constructed by the property owner for access to the property, which shall be maintained by the property owner or occupants.

112.7(2) Temporary access.

a. When an access is needed in temporary situations for a limited period of time, a temporary access connection may be allowed, but it is subject to special stipulations as determined by the department.

b. The location of the temporary access shall comply with all safety and sight distance requirements.

c. Temporary access, if authorized, may be permitted up to but not exceeding 24 consecutive months.

d. The permittee is responsible for all costs incurred, including removal of the access and restoration of the right-of-way at the end of the permit period.

e. An application for temporary access is not needed if the temporary access is for department purposes and has been approved in department internal documents and, when required, by the Federal Highway Administration.

761—112.8(306A) Drainage requirements for access connection approvals.

112.8(1) The permittee shall provide, at the permittee's expense, drainage structures for access connections that will become an integral part of the existing drainage system.

112.8(2) The type, size and condition of the drainage structures provided by the permittee must meet the requirements of the department in unincorporated areas and the requirements of both the department and the municipality in incorporated areas. The design and construction of drainage structures for access shall not adversely impact the highway right-of-way, a storm sewer system or a drainage-way.

112.8(3) The construction of an access shall not impair the drainage or stability of the highway subgrade, nor shall it cause water to flow across the roadway pavement or pond on the shoulders or in the ditch or result in erosion within the highway right-of-way.

112.8(4) Drainage systems designed and constructed by the department within the highway right-of-way are designed to serve the drainage needs of the highway and adjoining properties based on the basin conditions at the time of the design of the highway.

761—112.9(306A,318) Violations at access connections.

112.9(1) It is the responsibility of the property owner and permittee to ensure that the access is not in violation of this chapter or the terms and conditions of the permit.

112.9(2) When an authorized access is constructed or used in violation of this chapter or the terms and conditions of the permit, the department may suspend the access permit and may order the

immediate closure of the access. Notwithstanding the preceding sentence or any other provision of this chapter, the department may proceed as authorized under Iowa Code chapter 318 at any time.

These rules are intended to implement Iowa Code chapter 17A and sections 306.19, 306A.1 through 306A.8, 307.12(1)“j,” 318.3, 318.5 and 318.8.

ARC 8247C

TRANSPORTATION DEPARTMENT[761]

Notice of Intended Action

Proposing rulemaking related to junkyard control and providing an opportunity for public comment

The Transportation Department hereby proposes to rescind Chapter 116, “Junkyard Control,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 306C.2 through 306C.4, 306C.6 and 307.12(1)“j.”

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 306C and 23 U.S.C. Section 136.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 116 in compliance with Executive Order 10. Proposed Chapter 116 continues existing practices for the handling of junkyards that are visible to the national highway system. No new restrictions are being placed upon owners of junkyards. Chapter 116 complies with 23 U.S.C. Section 136 and preserves highway funding. The Department follows the minimum standards accepted by the Federal Highway Administration in order to avoid a 7 percent reduction on the annual federal highway apportionment to the State of Iowa.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on May 1, 2024. A public hearing was held on the following date(s):

- May 21, 2024

The Department received no comments.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 8, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 6, 2024 9 to 9:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 536 436 610
November 8, 2024 1 to 1:30 p.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 769 718 494

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 116 and adopt the following **new** chapter in lieu thereof:

CHAPTER 116
JUNKYARD CONTROL

761—116.1(306C) Definitions. The definitions in Iowa Code section 306C.1 apply to this chapter. In addition:

“*Adjacent area*” means an area that is contiguous to and within 1,000 feet of the nearest edge of the right-of-way of any highway on the national highway system.

“*Automobile graveyard*,” as used in Iowa Code section 306C.1, means any site that is maintained, used, or operated for storing, keeping, buying, or selling ten or more wrecked, scrapped, ruined, dismantled or inoperative motor vehicles, but does not include any location where motor vehicle bodies are placed along stream banks for purposes of bank stabilization and soil erosion control, if such placement conforms with guidelines established by the department of natural resources.

“*Industrial activities*” means activities that are generally permitted only in industrial or heavier zone classifications by zoning authorities within the state, except that none of the following are considered to be industrial activities:

1. Outdoor advertising structures.
2. Agricultural, forestry, ranching, grazing, farming and related activities, including but not limited to wayside fresh produce stands.
3. Activities normally and regularly in operation less than three months of the year.
4. Transient or temporary activities.
5. Activities not visible from the main traveled way.
6. Activities more than 300 feet from the nearest edge of the main traveled way within the corporate limits of cities.
7. Activities more than 1,000 feet from the nearest edge of the main traveled way outside the corporate limits of cities.
8. Activities conducted in a building principally used as a residence.
9. Railroad tracks, minor sidings, and passenger depots.
10. Junkyards.

"Industrial zone" means a zone established by zoning authorities as being most appropriate for industry or manufacturing. A zone that simply permits certain industrial activities as an incident to the primary land use designation is not considered to be an industrial zone.

"Inoperative motor vehicle" means any of the following:

1. A motor vehicle that does not have a valid title.
2. A motor vehicle that does not have a current registration unless the motor vehicle is in the inventory of a motor vehicle dealer licensed under Iowa Code chapter 322.
3. A motor vehicle with one or more of the following items missing or in need of substantial repair: windshield, driver's seat, steering wheel or steering system, battery, ignition system, fuel tank or fuel supply system, engine, transmission, drive shaft, differential, axle, suspension system, brake system, or frame.
4. A motor vehicle that is not immediately capable of legal operation on a public road or street.

However, any one of the following by itself does not render a motor vehicle inoperative: a battery that can be recharged, one tire and wheel missing or in need of repair, or lack of fuel.

"Main traveled way" means the portion of the roadway for movement of vehicles on which through traffic is carried, exclusive of shoulders and auxiliary lanes. In the case of a divided highway, the main traveled way includes each of the separated roadways for traffic moving in opposite directions, exclusive of shoulders, auxiliary lanes, frontage roads, turning roadways, and parking areas.

"Nonconforming junkyard" means a junkyard located in an area not exempted by Iowa Code section 306C.2 and that was lawfully established:

1. Prior to July 1, 1972, and is located within the adjacent area of an interstate highway.
2. Prior to May 6, 2015, and is located within the adjacent area of a noninterstate highway on the national highway system.
3. Prior to the effective date of a zoning change that caused nonconformity with these rules.
4. Prior to the departure or closure of an industrial activity that caused nonconformity with these rules.
5. Prior to the establishment of a highway as part of the national highway system.

"Right-of-way" means land area dedicated to public use for the highway and its maintenance, and includes land acquired in fee simple or by permanent easement for highway purposes but does not include temporary easements or rights for supplementary highway appurtenances.

"Unzoned industrial area," as used in Iowa Code sections 306C.2 and 306C.3, means land occupied by a regularly used building, parking lot, storage area or processing area of an industrial activity, and land within 1,000 feet thereof that is:

1. Located on the same side of the highway as the activity,
2. Not predominantly used for residential or commercial purposes, and
3. Not zoned by state or local law, regulation, or ordinance.

This rule is intended to implement Iowa Code sections 306C.1 through 306C.9 and 23 U.S.C. Section 136 as implemented through 23 CFR 751.

761—116.2(306C) Screening or removal costs. Screening or removal shall be paid for and provided by the following:

116.2(1) The department, only for nonconforming junkyards and subject to Iowa Code sections 306C.3 and 306C.5.

116.2(2) The owner, for junkyards established within the adjacent area of a highway on the national highway system in an area not exempted by Iowa Code section 306C.2, or for nonconforming junkyards that have expanded in size since becoming nonconforming.

This rule is intended to implement Iowa Code sections 306C.3 and 306C.5.

761—116.3(306C) Screening standards.

116.3(1) *Composition.* Screens may be natural or manmade, but all screens shall be of a height and type to provide year-round obscurement of the contents.

a. Natural screens may consist of nondeciduous plantings, provided the variety, size, and growth rate will obscure the site within a reasonable time period. Earthen berms or existing natural features on the site may also be incorporated into the screening solution.

b. Manmade screens may consist of any variety of materials, provided the screen is constructed in a sturdy, permanent manner and blends with the natural surroundings. Buildings may be incorporated into the screening solution, but inoperative motor vehicles may not be stacked or arranged as a component of the screening feature.

116.3(2) *Screening plan.* For junkyards that are not exempted by Iowa Code section 306C.2, a screening plan should be submitted to the department for review before investing in plants, materials, and labor. This allows for the department to review the plan to ensure that the proposed screen will completely obscure the contents of the site from view, will be structurally sound, and will blend in with the natural surroundings for the area. While submitting a screening plan is not required, doing so adds confidence that investments made will yield the desired result.

This rule is intended to implement Iowa Code sections 306C.3 and 306C.4 and 23 U.S.C. Section 136 as implemented through 23 CFR 751.

761—116.4(306C) Removal. Removal or relocation of contents to areas not viewable from the highway may be necessary for the following reasons:

116.4(1) The difference in elevation between the highway and junkyard is such that a screen tall enough to completely obscure the site is not cost-effective.

116.4(2) The owner is financially unwilling or otherwise unable to complete the installation of or maintain a screen that can pass review by the department.

116.4(3) Local regulations do not permit the construction of screening of such type that would provide complete obscurement.

This rule is intended to implement Iowa Code sections 306C.2, 306C.3 and 306C.5.

761—116.5(306C) Notice and enforcement.

116.5(1) *Notice.* The department may provide a 30-day written notice by certified mail to the owner of a junkyard and, if not the same person or entity, the owner of the property, demanding that steps be taken to bring a site into compliance. Steps may include but are not limited to the submission of a screening plan, completion of a screen, and extending or repairing a screen.

116.5(2) *Enforcement.* If the junkyard remains out of compliance after notice is served and steps toward compliance are not accomplished within the time frames prescribed by the department, the department may apply for an injunction to abate the public nuisance as provided in Iowa Code section 306C.6.

This rule is intended to implement Iowa Code sections 306C.4 and 306C.6.

761—116.6(17A) Hearings and appeals. A person who is aggrieved by a decision of the department and who is entitled to a hearing may contest the decision pursuant to 761—Chapter 13.

This rule is intended to implement Iowa Code chapter 17A.

761—116.7(306C) Contact information. Inquiries regarding this chapter may be directed to the Advertising Management Section, Traffic and Safety Bureau, Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone 515.239.1255.

This rule is intended to implement Iowa Code sections 306C.1 through 306C.9.

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TRANSPORTATION DEPARTMENT[761]

Notice of Intended Action

Proposing rulemaking related to outdoor advertising and providing an opportunity for public comment

The Transportation Department hereby proposes to rescind Chapter 117, “Outdoor Advertising,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 306B.4 through 306B.6, 306C.11, 306C.18, 306C.24, 306D.4 and 307.12(1)“j.”

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapters 306B, 306C and 306D; 23 U.S.C. Section 131; and 23 CFR Part 750.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 117 in compliance with Executive Order 10. Proposed Chapter 117 eliminates redundancies and any unnecessary restrictions that are not contained in federal requirements or that do not directly further the legislative intent of Iowa Code chapter 306B, 306C, or 306D.

The Highway Beautification Act, 23 U.S.C. Section 131, was passed in 1965 and was intended to protect the public’s investment in the primary highway system, promote the safety and recreational value of public travel, and preserve natural beauty alongside the roadway. The prohibition on outdoor advertising signs in rural, residential, and other areas not considered commercial or industrial was a key element to this law. This chapter and Iowa Code establish and maintain “effective control” of outdoor advertising signs adjacent to the primary highway system in Iowa.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on March 20, 2024. A public hearing was held on the following date(s):

- April 11, 2024

The Department received public comments from Scenic America that were generally supportive. One editorial correction was made within paragraph 117.6(2)“c” regarding the due date of June 30. The date certain of 23 CFR Section 750.154 contained within paragraph 117.2(4)“e” was changed to October 1, 2024.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 5, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 6, 2024 10 to 10:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 200 397 224
November 8, 2024 2 to 2:30 p.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 539 194 627

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 117 and adopt the following **new** chapter in lieu thereof:

CHAPTER 117
OUTDOOR ADVERTISING

761—117.1(306B,306C) Definitions. The definitions in Iowa Code section 306C.10 are adopted. In addition:

“*Abandoned sign*” means an advertising device for which the owner has failed to timely apply for the required outdoor advertising permit(s) or has failed to timely pay the required fee(s).

“*Blank sign*” means an advertising device for which any of the following conditions exist:

1. The face does not display advertising copy.
2. The face has been removed.

3. The entire advertising device has been removed or does not exist at the permitted location.

“Daylight area” means a triangular area formed by a line connecting two points each back (50 feet in city, 100 feet in unincorporated area) from the point where the right-of-way lines of the main traveled way and an intersecting street meet or would meet if extended.

“Destroyed” means that at least 60 percent of the supports are broken, if wooden, or broken, bent or twisted, if metal, such that normal repair practices would call for the replacement of the damaged supports.

“Face” means that part of an advertising device that is devoted to the display of advertising and that is visible to traffic proceeding in any one direction.

“Interchange” means the entire area constructed for a junction of two or more public streets or highways by a system of separate levels that permit traffic to pass from one level to another without the crossing of traffic streams. This includes all acceleration and deceleration lanes constructed to accommodate this movement of traffic.

“LED display” means a face, as defined herein, displaying a message that is formed by light-emitting diodes and that is changed by an electronic process. An LED display is a single face.

“Modification” means any addition to or change in dimensions, lighting, structure or advertising face, except as incidental to the customary maintenance of an advertising device.

1. A change in the number or type of support posts is a modification. A change in dimensions is a modification. However, the addition of extensions or cutouts, including forward projecting, is not a modification if the extensions or cutouts are added for a period of 90 days or less and if they are illuminated only by existing sign lighting and do not contain internal lighting.

2. A lawful change in advertising message is not a modification. The use of a vinyl overlay or wrap on either a poster panel or paint unit is a change in advertising message, not a modification.

3. On an advertising device that conforms to all current requirements, the replacement of one metal-framed face with another metal-framed face of the same size, using dissimilar component parts or assembly methods, or both, is not a modification.

4. The addition of LED display capabilities to an advertising device is a modification.

5. The elimination of trim surrounding the area used for advertising copy is not a modification, provided the advertising copy retains the same dimensions as the original advertising copy.

“Nonconforming sign” means an advertising device that was lawfully erected and continues to be lawfully maintained, but that does not comply with current requirements due to changed conditions, such as a change in zoning, establishment of a new highway, or a similar change that affects compliance.

“Regularly used” means open for business and staffed by an owner or employee for at least 20 hours per week, on property assessed as commercial or industrial by the jurisdiction having authority, and with the hours of operation visibly posted on the premises. The department may delay action on the permit application for up to 180 days from the date of the application in order to conduct periodic checks on the site as necessary to determine whether the purported commercial or industrial activity meets this definition. A rental storage business is excepted from the staffing requirement if it has 24-hour access for customers and a minimum of 50 units, each occupying at least 50 square feet, individually separated, and enclosed by walls.

“Scenic area,” as used in Iowa Code section 306C.13, means any area of particular scenic beauty or historical significance, as determined by the federal, state or local officials having jurisdiction of the area. It includes real property interests that have been acquired for the restoration, preservation and enhancement of scenic beauty.

“Tri-face device” means an advertising device with three singular faces attached to one common structure in a triangular configuration.

“Tri-vision device” means an advertising device that has an advertising face with a mechanical device that allows three advertising messages to be alternately visible to traffic proceeding in any one direction. Each message is attached to individual vertical or horizontal louvers, which are mechanically rotated to change the message.

“Widening,” as used in Iowa Code section 306C.13, means the point at which it is detectable that a deceleration or exit ramp is beginning to form alongside the main traveled way, or an acceleration or

merging ramp has tapered to a close alongside the main traveled way. In the case where an entrance ramp becomes an auxiliary lane and the auxiliary lane becomes an exit ramp at the adjacent interchange, the widening shall be the point at which a deceleration ramp completely separates from the main traveled way as evidenced by the inside lane marking of such ramp, or an acceleration ramp joins with the main traveled way as evidenced by the inside lane marking of the ramp intersecting with the outside lane marking of the main traveled way.

761—117.2(306B,306C) General provisions.

117.2(1) Scope. This chapter pertains to all advertising devices that are visible from the main traveled way of any primary highway, except for the following:

- a. Advertising devices within incorporated areas that are beyond 660 feet from the nearest edge of the right-of-way.
- b. Official traffic control devices, logo signing and tourist-oriented directional signing.
- c. Advertising devices erected within the right-of-way of any primary highway; such devices are subject to Iowa Code chapter 318.

117.2(2) Rebuttable presumption. The department may regulate signs as advertising devices except when sufficient documentation from persons reasonably identified as potential payors or receivers of remuneration is available to the department showing or certifying that remuneration does not exist.

117.2(3) Contact information. Inquiries, requests for forms, and applications regarding this chapter may be directed to the Advertising Management Section, Traffic and Safety Bureau, Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. Similar information is also available at www.iowadot.gov/iowaroadsigns/sign-programs-and-applications/advertising-signs.

117.2(4) Advertising devices permitted under the private directional sign program between May 26, 1983, and July 1, 2021. Any advertising device permitted as a private directional sign by the department between May 26, 1983, and July 1, 2021, may continue to exist, even if nonconforming to this chapter, under the following conditions:

- a. The permit is renewed each year by payment of a \$15 fee on or before July 1.
- b. The permit remains issued to the owner of the permit on record with the department on July 1, 2021.
- c. The advertising device is not modified or destroyed.
- d. The advertising device is properly maintained with legible copy.
- e. The design and display of the advertising device meet federal standards contained in 23 CFR Section 750.154 as amended to October 1, 2024.

761—117.3(306B,306C,306D) General criteria.

117.3(1) Limitations. In addition to the standards contained in Iowa Code section 306C.13, advertising devices shall not be erected or maintained:

- a. That attempt or appear to attempt to direct the movement of traffic.
- b. That move or have any animated or moving parts in areas subject to Iowa Code chapter 306B.
- c. That contain LED displays, unless each advertisement remains in a fixed position on the display screen for at least eight seconds, transitions between advertisements occur within one second, and advertisements are not flashed, rolled, scrolled, or moved in any way on the display screen.
- d. Within the adjacent area of a designated scenic byway, unless the erection occurred prior to the date of designation, in which case subsequent permitting may occur in accordance with Iowa Code section 306C.18.

117.3(2) Measurements of distance. Measurements of distance for general spacing purposes are conducted in a horizontal manner parallel with the highway centerline. However, when determining the limits of the adjacent area defined in Iowa Code section 306C.10, measurements from the edge of the right-of-way are conducted in a horizontal manner perpendicular to the highway centerline.

117.3(3) Measurement of size. The size of an advertising device is determined by measuring the smallest square, rectangle, triangle, circle or combination thereof that will encompass the entire display

area including border and trim, but excluding temporary cutouts and extensions, base, apron, support, and other structural members.

117.3(4) Zoning exclusions. The following zoning actions are not commercial or industrial zones for advertising control purposes:

- a. A zone in which limited commercial or industrial activities are permitted incidental to other primary land uses.
- b. Action that is not a part of comprehensive zoning in accordance with Iowa Code chapter 335 or 414.
- c. Action taken primarily to permit advertising devices.

761—117.4 Reserved.

761—117.5(306B,306C) Location, size and spacing requirements.

117.5(1) *Advertising devices lawfully in existence prior to July 1, 1972.*

a. An advertising device that was lawfully in existence prior to July 1, 1972, including a device located beyond the adjacent area in unincorporated areas, may remain in existence without conforming to the location, size and spacing requirements in this rule provided that a permit is maintained in accordance with rule 761—117.6(306C).

b. If the advertising device is located in an adjacent area that is neither a zoned nor an unzoned commercial or industrial area, the device may remain in existence as described in paragraph 117.5(1)“a” only until such time as the device is acquired by the department. The permit issued for the device will be a provisional permit in accordance with Iowa Code section 306C.18(3) and subject to acquisition in accordance with rule 761—117.9(306B,306C).

117.5(2) *Advertising devices erected after July 1, 1972.* Except as otherwise provided in subrule 117.2(4), advertising devices shall not be erected after July 1, 1972, or subsequently maintained except for those that comply with Iowa Code chapters 306B and 306C and the following criteria:

a. *Commercial or industrial area.* Eligible areas for permitting are limited to the following three areas:

(1) Adjacent to interstate highways; areas that are zoned and used for commercial or industrial purposes in accordance with Iowa Code section 306B.2; within 750 feet of the regularly used portion of a commercial or industrial activity visible from the main traveled way; and on the same individual, platted parcel of land as that commercial or industrial activity.

(2) Adjacent to noninterstate primary highways; areas that are zoned commercial or industrial.

(3) Adjacent to noninterstate primary highways; areas that meet the definition of an unzoned commercial or industrial area.

b. *Spacing.* In addition to the standards contained in Iowa Code sections 306B.2 and 306C.13, the following requirements apply:

(1) Spacing standards apply to advertising devices for all highways from which the devices are visible, when more than one highway is in the vicinity of the advertising device.

(2) Spacing standards default to unincorporated spacing when both incorporated and unincorporated areas exist within the adjacent area on either side of the highway. However, daylight spacing may be determined by whether the subject location itself is within or outside of the incorporated municipality.

(3) Advertising devices subject to the daylight area spacing exemption in Iowa Code section 306C.13(5) are considered in conformity with that Iowa Code section if the catwalk or light ballasts extend out further than the 12 inches specified, provided such parts do not overhang the right-of-way. If the building from which the device is mounted is removed, the permit is revoked.

(4) Applications for advertising devices proposed in a location that meets the spacing requirements for that location, but that create a nonconformity to exist with another permitted advertising device, will be denied or adjusted so that the nonconformity is not created.

c. The following types of advertising devices are eligible for permits:

- (1) Single face devices; one permit required.

- (2) Back-to-back devices; two permits required.
- (3) V-type devices with the inside angle formed by the two faces not exceeding 60 degrees so that both faces are not readable upon approach; two permits required.
- (4) Devices commonly referred to as side-by-sides or double-decks are classified as either single face, back-to-back, or v-type, as provided in this paragraph. However, provisions do not exist for panels of copy that may be oriented in the same direction, but that are not lined up on the same vertical and horizontal planes, or that are not physically connected to the same structure with more than two feet of distance between them, or that are owned by different entities.
- (5) Tri-face devices are classified as v-type devices for permitted purposes from the primary highway in which the two faces are visible. If visibility of the third face exists due to a turn in the highway or another primary highway exists in the vicinity, a third permit is required.
- (6) Tri-vision devices, with a rotation occurring not more rapidly than four seconds for each display, are classified as either single face, back-to-back, or v-type, as provided in this paragraph, depending upon the structure.

761—117.6(306C) Outdoor advertising permits and fees required.

117.6(1) Application. Application for a permit for any advertising device subject to subrule 117.2(1) shall be made in accordance with Iowa Code section 306C.18 within the following time frames:

- a. On or before July 31, 1972, for advertising devices in existence on July 1, 1972.
- b. Prior to the erection of the advertising device, if erected after July 1, 1972.
- c. Within 30 days of receiving notice from the department that a lawfully erected advertising device that was not subject to subrule 117.2(1) has become subject to subrule 117.2(1) for reasons including but not limited to the establishment of a new primary highway or a change in the designation of a roadway to a primary highway.

117.6(2) Fees. Fees are applicable to all advertising devices measuring over 32 square feet in size.

- a. The initial fee, payable at the time of application, is \$100 per permit. This fee is not refundable unless the application is withdrawn prior to the department's field review of the proposed location.
- b. The annual renewal fee for each permit, due on or before June 30 of each year, is as follows:

<u>Area of Sign</u>	<u>Annual Renewal Fee</u>
33 to 375 square feet	\$15
376 to 999 square feet	\$25
1,000 square feet or more	\$50

- c. The payment of an annual renewal fee, if postmarked on or before June 30 of each year or otherwise delivered to the department on or before June 30 of each year, automatically renews the existing permit for the device for which the fee was paid.

- d. A permit for which the fee was not paid in a timely manner expires on July 1 of each year. If an advertising device is still in existence, it is considered abandoned. If the owner wishes to reapply for a permit to retain the device, the device and location will be reviewed in the same way that a review is conducted for a newly proposed advertising device.

- e. Renewal fees are not refundable and are not prorated.

117.6(3) Highway improvement projects. The department shall not prevent nor unnecessarily delay the issuance of a permit for the reason of a proposed future highway improvement project, except under any of the following conditions:

- a. The property upon which the advertising device is proposed has been appraised for the purposes of acquisition.
- b. Contact by department staff has been made with the property owner regarding compensation for the affected area.
- c. The placement of the advertising device would fail to meet the requirements of an existing corridor preservation plan in effect for the proposed location.
- d. A construction contract for the project has been initiated by the department.

117.6(4) *Permit plate.* Upon approval of the application, the department will issue a numbered metal permit plate for the advertising face. This permit plate shall be securely attached to the advertising device in a manner that the plate is unobstructed from view from the highway. If the plate is not displayed, the department may provide notice to the owner that the plate is to be displayed within 90 days. If after that period of time the plate is not displayed, the department may cancel the permit.

117.6(5) *Reconstruction or modification.* A new permit is required from the department prior to the reconstruction or modification of a permitted advertising device.

a. Permit applications will be reviewed for compliance with Iowa Code chapter 306C and this chapter; nonconforming signs are not eligible for permit approval for reconstruction or modification.

b. Reconstruction or modification of an advertising device prior to the issuance of the permit needed to conduct such action shall result in revocation of the existing permit that has been issued for the advertising device. This may result in the removal of the advertising device in the manner specified in subrule 117.8(1) if the device is not eligible for permitting in accordance with this chapter or Iowa Code chapter 306B or 306C.

117.6(6) *Access.* Access to the private property upon which an advertising device is located shall be gained only from legal accessways through private property, local streets, secondary roads, or from the primary highway right-of-way through access points designated or allowed by the department in accordance with 761—Chapter 112. Unauthorized use of the primary highway right-of-way for the purpose of constructing or maintaining an advertising device may be cause for permit revocation and removal of the device. The department will issue a warning letter to the owner of the permit following the first instance of unauthorized use; a second instance will result in the revocation of the permit followed by a 12-month period where no new permits may be issued to that person or entity in the same location, or within 500 feet of the same location. The existing device for which the permit was revoked is subject to removal in accordance with Iowa Code section 306C.19.

117.6(7) *Vegetation in the right-of-way.* No vegetation in the right-of-way may be removed, trimmed, poisoned, or altered so that the viewing time can be improved for an advertising device, unless written authorization is received from the department and the conditions included in the authorization are followed. Proceeding to remove, trim, poison, or alter vegetation without such authorization may result in the revocation of the permit for the device and the removal of the device in accordance with subrule 117.8(1). In addition, the department may suspend permit approvals for a 12-month period for any location within 500 feet of the location of the former permit.

117.6(8) *Use and condition.*

a. The maximum period of time in which an advertising device may qualify as a blank sign is six months.

b. The maximum period of time in which an advertising device may have illegible copy or be in a state of disrepair is 90 days.

c. If the department determines that an advertising device has been blank for a period of time exceeding six months, or has illegible copy or is in a state of disrepair for a period of time exceeding 90 days, the department may issue a notice pursuant to rule 761—117.8(306B,306C) in which the owner has 30 days to either cause it to conform or to remove it.

117.6(9) *Destroyed sign.*

a. The permit for an advertising device that has been destroyed will automatically be revoked.

b. An advertising device that has been destroyed is in a condition that, if repaired, would meet the definition of reconstruction in Iowa Code section 306C.10 and is subject to subrule 117.6(5). Whether the device can be reconstructed will depend upon whether it conforms to this chapter and Iowa Code chapters 306B and 306C.

c. An advertising device that has been damaged, but not destroyed, may be repaired. The repair is not deemed an act of reconstruction.

761—117.7 Reserved.

761—117.8(306B,306C) Removal procedures.

117.8(1) Advertising devices subject to this chapter that have been abandoned, or illegally erected or maintained, may be removed, or caused to be removed, by the department after 30 days' notice in accordance with Iowa Code section 306C.19.

117.8(2) Advertising devices removed by the department may be reused, scrapped or disposed of by the department with no compensation paid to the owner.

117.8(3) Revocation of a permit may be included as part of the 30 days' notice, if served by restricted certified mail or by personal service.

761—117.9(306B,306C) Acquisition of advertising devices that have been issued provisional permits.

117.9(1) The department will acquire an advertising device for which a provisional permit has been issued only if all of the following conditions are met:

- a.* Acquisition is required by federal law.
- b.* All necessary federal and state funding is available for the purpose.
- c.* The permit has not been revoked.

117.9(2) If the advertising device will be acquired, the department will use the following procedure:

a. A written notice of the department's intent to revoke the provisional permit and acquire the device will be mailed or delivered to the owner of the advertising device and to the owner of the land upon which the device is located. The notice will include an offer to purchase the advertising device. If good-faith negotiations with the owner of the device and the owner of the land upon which the device is located do not result in a mutually agreeable sale price, the department may revoke the provisional permit and initiate condemnation proceedings as provided in Iowa Code chapter 6B.

b. In the event of condemnation, possession will be taken of the advertising device as soon as the award has been deposited with the sheriff.

761—117.10(17A,306C) Contested cases.

117.10(1) An applicant who has been denied an outdoor advertising permit by the department may timely contest the decision in accordance with 761—Chapter 13. A request is considered timely if submitted in writing to the director of the traffic and safety bureau at the address in subrule 117.2(3) and delivered or postmarked within 30 days of the department's mailing of the letter denying the application.

117.10(2) The owner of an outdoor advertising permit that has been revoked or canceled by the department may timely contest the decision in accordance with 761—Chapter 13. A request is considered timely if submitted in writing to the director of the traffic and safety bureau at the address in subrule 117.2(3) and delivered or postmarked within 30 days of the owner's receipt of the revocation notice issued by the department.

117.10(3) Failure to timely request a hearing on the denial, revocation, or cancellation of a permit is a waiver of the right to a hearing and a failure to exhaust administrative remedies.

These rules are intended to implement Iowa Code chapters 306B and 306C and section 306D.4 and 23 U.S.C. Section 131 and 23 CFR Section 750.705.

ARC 8249C**TRANSPORTATION DEPARTMENT[761]****Notice of Intended Action****Proposing rulemaking related to logo signing
and providing an opportunity for public comment**

The Transportation Department hereby proposes to rescind Chapter 118, "Logo Signing," Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code sections 306C.11 and 307.12(1)“j.”

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 306C.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 118 in compliance with Executive Order 10. Proposed Chapter 118 establishes standards and conditions for the placement of logo signs along the interstate system in Iowa in accordance with Iowa Code section 306C.11. The logo signing program operates within certain guidelines contained in the federal Manual on Uniform Traffic Control Devices (MUTCD), which contains national standards for the placement of official traffic signs placed within the public rights-of-way.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on May 1, 2024. A public hearing was held on the following date(s):

- May 21, 2024

The Department received one comment, and no changes from the Regulatory Analysis have been made. The Wisconsin-based Kwik Trip, Inc. (doing business as Kwik Star in Iowa) supports the inclusion of electric vehicle (EV) charging stations as a new category of signing along with gas, food, lodging, etc. The Department is aware that the recently revised MUTCD provides for EV charging as a new category of signing. Although the Department follows the MUTCD pursuant to 761—Chapter 130, it must do so using the version officially adopted by the Department. Adoption of the new version of the MUTCD is planned for calendar year 2025. Therefore, while the Department supports the concept, accommodations to allow EV charging stations as a new category under Chapter 118 will need to be incorporated after 761—Chapter 130 is repromulgated.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 8, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 6, 2024 1 to 1:30 p.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 639 035 248
November 8, 2024 10 to 10:30 a.m.	Microsoft Teams link Or dial: 515.817.6093 Conference ID: 685 941 041

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 118 and adopt the following **new** chapter in lieu thereof:

CHAPTER 118
LOGO SIGNING

761—118.1(306C) Introduction. Logo signing consists of individual business signs attached to specific service signs erected by the department within the right-of-way of interstate and freeway-primary highways. The purpose of logo signing is to provide specific motorist service information of interest to the traveling public in accordance with the “Manual on Uniform Traffic Control Devices,” (MUTCD) as adopted in rule 761—130.1(321). The department will perform all installation, maintenance, removal and replacement services for business signs within the right-of-way. The business signs are provided by the applicants.

761—118.2(306C) Definitions.

“*Business*” means an entity that provides a gas, food, lodging, or camping service or that is an attraction site.

“*Business sign*” means a separate sign attached to a specific service sign; the business sign shows the name, symbol or trademark of a business that provides the type of motorist service identified on the specific service sign.

“*General service sign*” means an official guide sign that identifies general road user services, such as gas, food, lodging and camping. This sign does not provide for the placement of business signs.

“*Main line*” means the main-traveled way of an interstate or a freeway-primary highway.

“*Meal*” means the service of food entrees and beverages between the hours of 8 a.m. to 10 a.m., 11 a.m. to 1 p.m., or 5 p.m. to 7 p.m.

“*Motorist service*” means one of the following five types of services: gas, food, lodging, camping or attraction.

“*Ramp*” means the exit lane that carries decelerating traffic away from the main line of an interstate or a freeway-primary highway.

“*Specific service sign*” means an official guide sign that identifies one or more types of motorist services, provides directional information, and has spaces for the attachment of business signs to identify businesses providing those services.

“*Trailblazing sign*” means a specific service sign erected on the road network accessed from an interchange that has logo signing; the sign directs motorists to a particular business signed on the main line and has spaces for the attachment of business signs.

“*Visible*” means able to be identified or comprehended by a person of visual acuity sufficient to be issued an Iowa driver’s license.

761—118.3(306C) Erection and location of specific service signs and placement of business signs.

118.3(1) General.

a. The department may erect specific service signs at rural interchanges if the requirements of this chapter are met and sufficient space is available. The department may also erect specific service signs at urban or nonrural interchanges if the requirements of this chapter are met and sufficient space is available. If sufficient space is not available for more than one specific service sign, the department may install a general service sign in lieu of a specific service sign.

b. Specific service signs may be erected at an interchange only when the motorist can conveniently reenter the interstate or freeway-primary highway and continue in the same direction of travel.

118.3(2) Main line specific service signs and placement of business signs. Following are the requirements for main line specific service signs erected in advance of an interchange, in a single direction of travel, and limitations regarding the number and types of business signs attached to these service signs:

a. A maximum of four main line specific service signs may be erected in advance of an interchange from which motorist services are available.

b. On the main line, the minimum spacing between specific service signs and between specific service signs and other official guide or destination signs is 800 feet.

c. If spacing limitations exist, preference may be given to available gas, food, lodging, camping or attraction services, in that order.

d. If services are displayed, the order of display of services in the direction of travel on successive main line specific service signs is as follows: attraction, camping, lodging, food, and gas.

e. Depending upon factors such as limited space for the placement of signs, limited interest from businesses, or limited availability of businesses, the department may combine up to three service types on one sign as provided in the MUTCD.

f. A maximum of six business signs may be displayed on a specific service sign, regardless of whether it displays a single service type or multiple service types.

118.3(3) Specific service signs erected along interchange ramps.

a. The department may erect specific service signs along interchange ramps to accommodate the placement of business signs similar to but smaller than the business signs used along the main lines, along with arrows and mileage indicators. Specific service signs along interchange ramps are available for the participating businesses that are not visible or that are only marginally visible from the traveled portion of the interchange area.

b. The department may opt to erect general service signs in lieu of specific service signs along interchange ramps, or not erect any service signs at all in cases where insufficient spacing exists for signs or where the ramps are directional with no turning decision to be made at a terminal.

118.3(4) Trailblazing signs.

a. Businesses that are not visible from the intersecting roadway will need to provide additional smaller versions of their business signs for installation on trailblazer service signs erected in advance of intersections where turns would be necessary.

b. If the proposed placement of a trailblazer service sign is not on the primary road system, the appropriate local jurisdiction will be provided with an opportunity to review the placement before the department proceeds with any specific service signing for the business. If the placement is approved, the department will route the appropriate signs to the local authority for installation.

c. If a trailblazer service sign is necessary, but the location is not conducive for placement or the local ordinance prevents such placement, an official traffic control device from another sign program or a lawfully placed outdoor advertising device may be used as a substitute, provided the sign is positioned to be effective at the intersection where it is needed.

d. If signing at the intersections where turns are necessary cannot be accomplished, the business does not qualify for participation in the logo program.

761—118.4(306C) Eligibility for placement of business signs on specific service signs. Participation in the logo program is limited to businesses that meet the following conditions:

118.4(1) The business is open to the general public; does not restrict entrance based on age; and conforms to all applicable laws concerning discrimination based on age, race, creed, color, sex, sexual orientation, gender identity, national origin, religion, and disability.

118.4(2) The business is located within three driving miles of the beginning of the exit ramp for the interchange. In commercially developed areas, the department may reduce the qualifying distance to one mile. In areas where services are limited, the department may increase the qualifying distance to 15 miles.

118.4(3) Service types. The business provides one of the following types of services in accordance with the associated criteria:

a. *Gas.* Provision for the sale of gasoline, oil, and potable water; the use of restroom facilities; and access to a public telephone or a cell phone. The business' operating times should be at least 16 hours per day, seven days per week. For 24-hour fuel dispensers, operable with the use of a widely accepted credit card, the provision of gas or alternative fuels is considered sufficient for qualification purposes.

b. *Food.* A restaurant or food service that provides all of the following: at least two meals per day, six days per week; employees, menu, cash register or point-of-sale, seating for at least ten customers, and an exterior sign, all of which are designated exclusively for the business being represented on the service sign; and the display of a state food service establishment license or, if operating within tribal lands, compliance with food service standards established by the local authority.

c. *Lodging.* A lodging facility, appropriately licensed, with bathrooms and telephones for each unit.

d. *Camping.* A campground with at least 20 available camping spaces, with a 24-hour contact for staff, and for which all state and local health and sanitation standards are met.

e. *Attractions.* One of the following attraction sites providing public restrooms and parking spaces for at least 30 customers, and being open at least five days per week totaling 40 hours or more per week, except if otherwise specified below:

- (1) Area of natural beauty or phenomena.
- (2) Historic site.
- (3) Cultural site or museum.
- (4) Scientific site.
- (5) Four-year accredited college or university.
- (6) Religious site.
- (7) Area of outdoor recreation.
- (8) Winery, brewery or distillery with on-site production, tours, gift shop, and tasting room.
- (9) Amusement park.
- (10) Botanical park or zoological facility.
- (11) Casino.
- (12) Stadium, coliseum, arena or racetrack with a seating capacity of at least 5,000 and open during scheduled events.
- (13) Antique mall with at least 20,000 square feet devoted to retail sales.
- (14) Area containing eight or more antique shops within a three-block radius.
- (15) Shopping mall or retail outlet with a minimum, active store count of 50, excluding kiosks and temporary booths within the common areas, and including only those stores that occupy owned or leased areas whose boundaries are defined by permanent walls with doors or gates.

(16) Sporting goods store or recreational retail outlet with at least 100,000 square feet devoted to retail sales.

(17) Cultural and entertainment district as officially designated by the department responsible for state economic development provided that the local jurisdiction implements a signing plan to direct motorists to the various cultural and entertainment sites within the district.

118.4(4) The business maintains all outdoor advertising signs in a manner that conforms to Iowa Code sections 306C.11 and 306C.13.

118.4(5) The business premises includes a sign identifying the business in a manner visible to traffic approaching the entrance from a public roadway.

118.4(6) The business remains eligible to participate in the signing program in accordance with this chapter. If it is determined that a business is no longer eligible, the department may remove the business sign immediately or provide notice allowing for a 30-day period for the business to make the necessary adjustments to restore eligibility.

761—118.5(306C) Application, drawing, and fees.

118.5(1) *Application.*

a. A business may request placement of a business sign upon a main line specific service sign by submitting a completed application form, provided by the department, along with the application fee, to the Advertising Management Section, Traffic and Safety Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

b. The department will review the application and site for compliance with this chapter. If the application is approved, the department will advise on how many business signs will be needed to fulfill the request.

c. The business signs will be provided by the business or applicant in accordance with rule 761—118.6(306C). The department may offer a noncomprehensive list of known sign fabricators as a courtesy to the applicant.

d. Approved applications are valid for the fiscal year (July 1 to June 30) and expire on June 30. If the fees, as billed by the department, are paid by the business in accordance with subrule 118.5(4), the application is renewed on July 1.

118.5(2) *Drawing to select applicants.* If the number of applicants for businesses exceeds the number of vacant spaces on a main line specific service sign, the department will hold a lottery drawing among these applicants to select the applicants to fill the vacant spaces.

118.5(3) *New application required for business name change.* If a business participating in the logo signing program changes its name or franchise affiliation from that which appears on its business sign, a new application is required. If the new application is received by the department prior to the change on the business premises, the business will retain its position on the specific service sign, the department will approve the application, and no application fee is due.

118.5(4) *Fees.*

a. *Application fee.* A fee of \$100 is required for an application submitted in accordance with subrule 118.5(3). The application fee is a one-time fee and is nonrefundable once the department has performed an on-site review to verify compliance with the requirements of this chapter.

b. *Annual fee.* The annual fee is \$230 for each business sign posted on a specific service sign and is due on or before July 1 of each fiscal year. However, for a new application, the annual fee will be prorated based on the remaining months left in the fiscal year.

c. *Service fee.* If business signs are replaced for any reason, including at the request of the business to reflect an updated design or at the request of the department in accordance with rule 761—118.7(306C), a service fee of \$50 per sign is due upon completion of the work by the department. If business signs need to be replaced, the department recommends supplying new business signs for replacement rather than refurbishing existing signs. If existing signs are to be removed, refurbished, and then reinstalled, the \$50 service fee is applied per sign, per service trip.

118.5(5) *Failure to pay annual fee or service fee.* Applications terminate when annual fees are not paid in full by July 1 of each year or when service fees are not paid within 30 days of receiving the

invoice from the department. In the event of termination, the business signs may be removed by the department, although such removal may occur at some point after the date of termination, depending upon the department's schedule and work priorities. If the termination was not voluntary, the business may reapply, subject to the requirements of this chapter, including payment of the application fee and a lottery drawing, where applicable.

118.5(6) *Fee options for seasonal operations.* Subject to subrule 118.5(5), a business that operates on a seasonal basis and is permitted to do so by this chapter has the following payment options:

a. Pay the annual fee for a full year. The department removes and reinstalls each business sign once each year, free of additional charge, coinciding with the dates of operation, if possible.

b. Pay the annual fee for a prorated year, based on the calendar months in which the business is in operation, plus a \$50 annual service fee per business sign for removal and reinstallation services performed. The department removes and reinstalls each business sign once each year, coinciding with the dates of operation, if possible.

c. Pay the annual fee for a prorated year, based on the calendar months in which the business is in operation, and provide business signs that contain a supplemental message indicating the dates of operation.

118.5(7) *Fees for temporary specific service signs.* In cases where the specific service sign is lacking or insufficient in size, and the projected date for installation or enlargement of the specific service sign by the department's contractor is undesirable for the applicant, the applicant may pay a special fee to expedite the installation of the business sign by having a small temporary specific service sign erected to provide a surface for the mounting of the business sign. The fee for the performance of this work is \$700 per main line specific service sign if none exists for that service type, \$400 per main line specific service sign if the existing sign is full, and \$300 per ramp specific service sign if similar work is needed along the ramp. The business signs furnished by the applicant will be the standard size and reused for placement on the primary specific service sign when it is available. Subject to availability of department resources, small temporary specific service signs will be installed within three months.

761—118.6(306C) Business sign fabrication. Upon approval of an application, the department will supply the necessary specifications for fabrication of the business signs to the applicant or applicant's sign fabricator. The applicant or applicant's sign fabricator shall submit a design proof to the department for approval before creating the business signs. If the department approves the submitted design, the sign fabricator may proceed to fabricate the signs and deliver them to the department's sign shop for inspection. All installation services are performed by the department or contractor on behalf of the department.

761—118.7(306C) Business sign replacement.

118.7(1) *Damaged business signs.* If a business sign is destroyed due to an errant vehicle or act of nature, the business, at its own expense, will need to furnish a replacement business sign. The department, due to an errant vehicle or act of nature, will waive any service fee associated in the work to replace the sign. If the specific service sign for which the business sign is attached can safely be repaired or re-erected while permanent repairs are on order through a contractor, the department will perform this work.

118.7(2) *Faded business signs.* The department may remove business signs that are faded or peeling after providing 60 days' notice to the business. If the business furnishes replacement business signs to the department in advance, the department may remove and replace business signs in the same service trip. This ensures continuity of signing and reduces department expenses.

118.7(3) *Updating a design.* If a business wants to update the design of a business sign, the process described in rule 761—118.6(306C) applies. The business will be billed in accordance with paragraph 118.5(4) "c."

These rules are intended to implement Iowa Code section 306C.11.

ARC 8252C**TRANSPORTATION DEPARTMENT[761]****Notice of Intended Action****Proposing rulemaking related to tourist-oriented directional signing
and providing an opportunity for public comment**

The Transportation Department hereby proposes to rescind Chapter 119, “Tourist-Oriented Directional Signing,” Iowa Administrative Code, and to adopt a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is proposed under the authority provided in Iowa Code section 307.12(1)“j” and section 321.252 as amended by 2024 Iowa Acts, Senate File 2385, section 317.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 321.252 as amended by 2024 Iowa Acts, Senate File 2385, section 317.

Purpose and Summary

This rulemaking proposes to repromulgate Chapter 119 in compliance with Executive Order 10 and 2024 Iowa Acts, Senate File 2385, section 17. Proposed Chapter 119 contains provisions and limitations for the erection of blue directional signs for businesses that are located within ten miles of a primary highway intersection in the nonurban areas of the state. The signs are installed by the Department within the right-of-way in advance of the intersection.

This chapter was significantly revised in early 2023, relaxing many of the entry qualifications for business owners interested in the program. The relaxed entry qualifications remain unchanged in the proposed repromulgated chapter, but an additional change is the elimination of the Tourist Signing Committee. This committee has provided a benefit for the program over the years by the committee’s diverse representation and input during rulemaking and review of applications. However, with the more relaxed entry qualifications from the 2023 rulemaking in place, and because 2024 Iowa Acts, Senate File 2385, section 317, amends Iowa Code section 321.252(3) to eliminate the Tourist Signing Committee, this additional layer of review and associated processing time is eliminated.

Regulatory Analysis

A Regulatory Analysis for this rulemaking was published in the Iowa Administrative Bulletin on July 10, 2024. A public hearing was held on the following date(s):

- July 30, 2024

The Department received no comments.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 761—Chapter 11.

Public Comment

Any interested person may submit written comments concerning this proposed rulemaking. Written comments in response to this rulemaking must be received by the Department no later than 4:30 p.m. on November 8, 2024. Comments should be directed to:

Tracy George
Department of Transportation
DOT Rules Administrator, Government and Community Relations
800 Lincoln Way
Ames, Iowa 50010
Email: tracy.george@iowadot.us

Public Hearing

Public hearings at which persons may present their views orally will be held as follows:

November 6, 2024
2:30 to 3 p.m.

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 275 901 22

November 8, 2024
9 to 9:30 a.m.

[Microsoft Teams link](#)
Or dial: 515.817.6093
Conference ID: 374 085 758

Persons who wish to make oral comments at a public hearing may be asked to state their names for the record and to confine their remarks to the subject of this proposed rulemaking.

Any persons who intend to attend a public hearing and have special requirements, such as those related to hearing or mobility impairments, should contact Tracy George and advise of specific needs.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rulemaking action is proposed:

ITEM 1. Rescind 761—Chapter 119 and adopt the following **new** chapter in lieu thereof:

CHAPTER 119
TOURIST-ORIENTED DIRECTIONAL SIGNING

761—119.1(321) Definitions.

“At-grade intersection,” for the purpose of this chapter, means an intersection of a primary highway and a secondary roadway, municipal street, or other primary highway, in which traffic may pass through the intersection at the same grade level as the intersecting roadway, or turn directly onto the intersecting roadway without the use of a ramp.

“Destination,” for the purpose of this chapter, means a business, service, activity, or site that meets the program requirements established in rule 761—119.3(321).

“Primary highway,” for the purpose of this chapter, means those roads and streets both inside and outside the boundaries of municipalities that are under department jurisdiction but does not include an interstate highway or a freeway primary highway as defined in Iowa Code section 306C.10.

“Tourist-oriented directional signing” means a system of guide signs with one or more sign panels that display the identification of and directional information for an eligible destination.

761—119.2(321) General.

119.2(1) *Conformance to MUTCD.* The department administers the tourist-oriented directional signing program in conformance with the “Manual on Uniform Traffic Control Devices” (MUTCD), as adopted in rule 761—130.1(321).

119.2(2) *Spacing and location.*

a. Tourist-oriented directional signing may be installed only when sufficient space is available. The determination of whether sufficient space is available is the responsibility of the department in accordance with the MUTCD and department policies.

b. Tourist-oriented directional signing may be installed only in advance of at-grade intersections where the motorist leaves the primary highway system to travel to the destination. Tourist-oriented directional signs may also be placed on a higher-classified highway to direct motorists onto a lower-classified highway, or on a greater-traveled highway to direct motorists onto a lesser-traveled highway, provided the signs are placed in advance of an at-grade intersection.

c. Tourist-oriented directional signing is limited to the rural areas and towns that are located outside of any urban areas established by the U.S. Census Bureau for incorporated municipalities with a population that meets or exceeds 5,000.

119.2(3) *Message.* The message on a tourist-oriented directional sign is limited to a descriptive name, a directional arrow, the travel distance to the destination, and in some cases for motorist services, an additional short word or acronym indicating an essential fuel type such as diesel, E-85, or EV (electric vehicle-charging station).

761—119.3(321) Eligibility for participation. Participation in this signing program is limited to destinations that meet the following criteria:

119.3(1) The destination is open to the general public for a minimum of four days per week and 20 hours per week. These hours are exclusive of any hours of operation that are by appointment, reservation or membership. The hours are conspicuously posted on the premises except for destinations that are open 24 hours per day.

119.3(2) Entrance to the destination is not granted based on age.

119.3(3) The destination derives a major portion of income or visitors from road users not residing in the area of the destination.

119.3(4) The destination is properly licensed by governing authorities relative to the nature of the activity engaged in by the destination.

119.3(5) The destination is located within ten miles of the intersection on the primary highway where the tourist-oriented directional signs will be placed.

119.3(6) The destination is located outside the boundaries of any urban area established by the U.S. Census Bureau for an incorporated municipality with a population that meets or exceeds 5,000.

119.3(7) The destination is not visible from the primary highway in a way that allows motorists time to safely react and make the turn. This program is not intended for businesses that enjoy adequate highway frontage for the placement of on-site signing.

119.3(8) The destination consists of buildings, facilities, and grounds that are safe, suitable, and appropriately designed and maintained for the intended purpose. If residential quarters co-exist in the same building, a convenient, well-marked, and separate entrance is available for patrons to access the activity identified on the sign.

119.3(9) The destination complies with all applicable laws concerning public accommodations without regard to age, race, creed, color, sex, sexual orientation, gender identity, national origin, religion or disability.

119.3(10) The destination complies with Iowa Code chapters 306B, 306C and 306D.

119.3(11) The destination, if seasonally operated, is open for a minimum of four consecutive weeks.

761—119.4(321) Application and approval procedure.

119.4(1) Applications for tourist-oriented directional signing may be submitted to: Advertising Management Section, Traffic and Safety Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. Information regarding the program may be accessed at www.iowadot.gov/iowaroadsigns or 515.239.1746.

119.4(2) The department may conduct measurements, take photographs, and collect information about destinations as necessary for evaluation purposes.

119.4(3) Applications that meet the requirements of this chapter will be approved.

119.4(4) Applications that do not meet the requirements of this chapter will be denied. The applicant will be informed of the reason for the denial.

761—119.5(321) Installation, maintenance, replacement and removal.

119.5(1) *Installation and maintenance of tourist-oriented directional signs.* Except as provided in subrule 119.5(4), the department will fabricate and perform the installation, maintenance, removal and replacement of tourist-oriented directional signs that are located within the right-of-way.

a. Upon approval of an application, the department will design the tourist-oriented directional sign and provide a scaled drawing of the tourist-oriented directional sign to the applicant, allowing the applicant to reconfirm interest before proceeding with fabrication.

b. Upon payment of the initial fee specified in subrule 119.5(3), the department will fabricate and install the tourist-oriented directional sign.

119.5(2) *Installation and maintenance of trailblazing signs.* Trailblazing signs are necessary when the destination is not located adjacent to the intersecting roadway.

a. The department may fabricate trailblazing signs and provide them to cities and counties for installation on secondary roads and city streets, if such placement does not violate any local ordinance, policy, or traffic manual.

b. The department will consult with the local authority to confirm that placement of a trailblazing sign is possible to guide the motorist to the destination.

c. Tourist-oriented directional signs may be installed only when all trailblazing signs may also be installed.

119.5(3) *Initial and renewal fees.* The initial fee, payable once an application is approved, is \$350 for each 72" × 18" sign placed along the primary highway and \$26 for each trailblazing sign placed along a nonprimary highway. These fees include the cost of sign fabrication and installation but do not include any additional requested fees by local jurisdictions for the placement of trailblazing signs along local road systems. The annual renewal fee, payable on or before June 30 of each year, is \$50 per sign, excluding trailblazing signs. This fee covers the administrative costs and normal maintenance.

119.5(4) *Seasonal destination.*

a. Seasonal destinations may be approved for the program if “closed” panels are installed over the directional information when the destinations are not open for the season or when the hours of operation are not meeting the minimum listed in subrule 119.3(1).

b. Destinations such as golf courses and Christmas tree farms where the expected seasonal period is generally known by motorists may forego the use of “closed” panels.

c. Destinations using “closed” panels may arrange to remove or reinstall the panels on their own through an agreement with the department or pay a fee to the department to perform the service. The fee is \$40 per trip and includes all signs associated with the destination that are located along the primary highway system.

119.5(5) *Replacement.* Tourist-oriented directional signs are constructed with high-quality materials designed to last many years. The department may, however, determine that a tourist-oriented directional sign needs to be replaced due to damage from vehicles, deterioration from age, or loss due to theft. In these cases, the cost for replacing the sign is the responsibility of the destination.

119.5(6) *Not-for-profit organizations.* A not-for-profit destination is exempted from all fees and costs associated with the installation and maintenance of a single set of signs at a location determined by the department to be the most reasonable approach to the destination. Additional locations may be

requested by the not-for-profit organization, and, if approved, such locations are subject to the associated fees and costs described in this chapter.

119.5(7) *Removal.* The department may remove a tourist-oriented directional sign if the destination no longer qualifies for tourist-oriented directional signing. As official signs, all removed tourist-oriented directional signs are retained as property of the department unless released to the destination for purposes other than display along any public roadway.

These rules are intended to implement Iowa Code section 321.252 as amended by 2024 Iowa Acts, Senate File 2385, section 317.

ARC 8258C

ECONOMIC DEVELOPMENT AUTHORITY[261]**Adopted and Filed****Rulemaking related to rescission of chapters**

The Economic Development Authority hereby rescinds Chapter 15, “STEM BEST Appropriation,” Chapter 21, “Division Responsibilities,” Chapter 50, “Division Responsibilities,” Chapter 54, “Iowa Targeted Small Business Procurement Program,” Chapter 101, “Mission and Responsibilities,” Chapter 114, “Iowa Innovation Council,” and Chapter 163, “Division Responsibilities,” Iowa Administrative Code.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 15.106A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 73 and sections 15.106A, 15.117A and 17A.3; 2021 Iowa Acts, House File 871; and 2022 Iowa Acts, House File 2564.

Purpose and Summary

Pursuant to Part IV of Executive Order 10, the Authority has been directed to initiate this rulemaking. The Authority hereby rescinds the following chapters:

- Chapter 15, regarding the STEM BEST appropriation. The Authority has transferred all funds to the current program administrator, the Department of Education.
- Chapters 21, 50, 101, and 163, which described the following divisions and activities of the Authority: the Community Development Division (Chapter 21), the Business Development Division (Chapter 50), innovation and commercialization activities (Chapter 101), and the Administration Division (Chapter 163). The Authority’s responsibilities are sufficiently described in the Iowa Code sections relating to the Authority and in 261—Chapter 1 relating to the overall organization of the Authority. Additionally, 2024 Iowa Acts, Senate File 2370, strikes Iowa Code section 17A.3(1)“a,” which required each agency to adopt rules describing its organization.
- Chapter 54, regarding the Iowa Targeted Small Business (TSB) Procurement Program. The Authority intends to include relevant information about the Authority’s role in TSB procurement in 261—Chapter 52 regarding TSB certification.
- Chapter 114, regarding the Iowa Innovation Council. The Council is sufficiently described in Iowa Code section 15.117A.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on July 24, 2024, as **ARC 8142C**. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Authority Board on September 20, 2024.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Authority for a waiver of the discretionary provisions, if any, pursuant to 261—Chapter 199.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on November 20, 2024.

The following rulemaking action is adopted:

- ITEM 1. Rescind and reserve **261—Chapter 15**.
- ITEM 2. Rescind and reserve **261—Chapter 21**.
- ITEM 3. Rescind and reserve **261—Chapter 50**.
- ITEM 4. Rescind and reserve **261—Chapter 54**.
- ITEM 5. Rescind and reserve **261—Chapter 101**.
- ITEM 6. Rescind and reserve **261—Chapter 114**.
- ITEM 7. Rescind and reserve **261—Chapter 163**.

[Filed 9/27/24, effective 11/20/24]

[Published 10/16/24]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/16/24.

ARC 8259C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Adopted and Filed

Rulemaking related to the Iowa targeted small business certification program

The Economic Development Authority hereby rescinds Chapter 52, "Iowa Targeted Small Business Certification Program," Iowa Administrative Code, and adopts a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 15.106A and 15.108(6).

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code chapter 73 and sections 12.44 and 15.108(6).

Purpose and Summary

Pursuant to Executive Order 10 (January 10, 2023), the Authority hereby rescinds Chapter 52 and adopts a new chapter in lieu thereof. The chapter describes the policies and procedures by which the Authority certifies targeted small businesses.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on July 24, 2024, as **ARC 8144C**. A public hearing was held on the following date(s):

- August 13, 2024
- August 15, 2024

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Authority Board on September 20, 2024.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Authority for a waiver of the discretionary provisions, if any, pursuant to 261—Chapter 199.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on November 20, 2024.

The following rulemaking action is adopted:

ITEM 1. Rescind 261—Chapter 52 and adopt the following **new** chapter in lieu thereof:

CHAPTER 52**IOWA TARGETED SMALL BUSINESS CERTIFICATION PROGRAM****261—52.1(15) Definitions.**

“Act” means the Iowa targeted small business procurement Act codified in Iowa Code chapter 73, subchapter III.

“Authority” means the same as defined in Iowa Code section 15.102(1).

“Certification” means the process that identifies small businesses as targeted small businesses and as eligible for technical assistance.

“Disability” means the same as defined in Iowa Code section 15.102.

“Minority person” means the same as defined in Iowa Code section 15.102.

“Program” means the targeted small business certification program described in this chapter and 261—Chapter 54.

“Service-disabled veteran” means a veteran who provides written verification from the U.S. Department of Veterans Affairs or the U.S. Department of Defense of a disability that was incurred or aggravated in the line of duty in active military, naval, air, or space service.

“Targeted group person” means a minority person, woman, person with a disability, or service-disabled veteran who is either an Iowa resident or a resident of a contiguous state who lives within 50 miles of the targeted small business the person owns, operates, and actively manages.

“Targeted small business” or *“TSB”* means the same as defined in Iowa Code section 15.102.

“Woman” means any female 18 years of age or older.

261—52.2(15) Certification.

52.2(1) A business must be certified as a targeted small business by the authority to participate in the program. Businesses seeking certification shall submit an application to the authority in the form and content required by the authority. The application will include information to establish whether a business meets the eligibility criteria of the program. An authorized representative of the business shall sign the application and an authorization to release information. Applications may be requested by contacting the authority or by visiting the authority’s website.

52.2(2) The authority reviews applications to determine whether a business is eligible to participate in the program pursuant to this chapter as in effect as of the date of application for certification. The authority will notify applicants in writing of its decision.

52.2(3) Certified businesses shall submit verification of continued eligibility to the authority at least every two years. The application for recertification will be provided by the authority. The authority will determine whether a certified business is eligible for recertification pursuant to this chapter as in effect as of the date of application for recertification.

52.2(4) A business that fails to provide any supplemental information requested by the authority may be denied certification or recertification.

52.2(5) Any business that is denied certification or decertified may reapply. The business bears the burden of demonstrating eligibility.

52.2(6) A certified business shall notify the authority within 30 days following a change in ownership or control of a certified business or if the targeted group person no longer actively manages the business. The notice must be accompanied by sufficient documentation to determine whether the business continues to be eligible for certification. The authority may require a business to submit a new application following a change in ownership, control, or management.

261—52.3(15) Eligibility. The authority will consider the following to determine whether a business is a targeted small business pursuant to Iowa Code section 15.102(12) and eligible for certification. Documentation may be required to prove each eligibility requirement. The authority may conduct on-site audits to evaluate eligibility.

52.3(1) Ownership. The authority will evaluate the following factors that indicate independent ownership by a targeted group person.

a. The business shall not be a subsidiary of any other business. If another business that is not a TSB has an interest in a TSB applying for certification, the authority will scrutinize the relationship between the businesses to determine the independence of the TSB. Recognition of the business as a separate entity for tax or corporate purposes is not solely sufficient to demonstrate independence.

b. The targeted group person owner(s) shall enjoy the customary incidents and profits of ownership and share in the risks commensurate with the owner’s ownership interest. The authority will

consider the substance rather than the form of the arrangements. Business arrangements that deviate from common industry practice may indicate an owner other than the targeted group person owns, operates, and actively manages a business.

c. At least 51 percent of the members of the business's board of directors must be targeted group persons.

d. At least 51 percent of the shares or other units of ownership of the business must be owned by one or more targeted group persons.

e. The business should be compensated for facilities, inventory, equipment, labor, or other items it owns and shares with any other business. Compensation shall not vary from common industry practice. If an applicant business is operated from the owner's residence, the residence and any adjacent outbuildings used by the applicant business may be owned jointly with other family members.

52.3(2) Decision-making authority. The targeted group person owner(s) shall have authority to incur liability and to decide financial and policy questions without any restrictions, either formal or informal.

a. The authority may review documents, including but not limited to minutes of board or owners meetings, bylaw provisions, operating agreements, certificates of organization, partnership agreements, charter requirements for cumulative voting rights, or employment agreements to determine the targeted group person's authority.

b. The targeted group person owner(s) shall make day-to-day decisions as well as major decisions on management policy and operation of the business. Authority to hire and to fire all personnel shall be vested in the targeted group person owner(s).

c. The authority will consider particular positions to determine who has major responsibility in a company. These people include but are not limited to those who:

- (1) Hold any applicable license;
- (2) Devote substantial time to the business;
- (3) Supervise or direct the supervision of management and field operations;
- (4) Manage financial affairs;
- (5) Prepare or approve bids or estimates;
- (6) Participate in price and bidding negotiations;
- (7) Make final decisions about staff and personnel;
- (8) Sign contracts and checks or authorize action on behalf of the business.

52.3(3) Expertise. The targeted group person owner(s) must have an overall understanding of, managerial and technical competence in, and expertise directly related to the type or nature of business in which the business is engaged and in the business's operations. Generally, expertise limited to office management, administration, or bookkeeping functions unrelated to the activities of the business is insufficient to demonstrate control of the business.

52.3(4) Capital contributions. Capital contributions by the targeted group person owner(s) to acquire interest in the business shall be real and substantial and reflected in documents such as stock certificates, articles of incorporation, minutes of board or owners meetings, partnership agreements, or income tax returns.

52.3(5) Capital contribution, expertise, and experience in an inherited business are not required. All other requirements apply.

52.3(6) Businesses that are owned and operated by one or more members of the same family will be closely scrutinized to determine whether the targeted group person identified as the owner of 51 percent or more of the business sets policy and makes day-to-day and long-term decisions for the operation and management of the business.

52.3(7) A previous or continuing employer-employee relationship between present owners will be closely scrutinized to ensure that the employee-owner has substantial management and decision-making responsibilities.

52.3(8) A disabled targeted group person must provide certification of the disability from a licensed medical physician, physician assistant, or nurse practitioner with relevant expertise or must have

been found eligible for vocational rehabilitation services by the department of workforce development, division of vocational rehabilitation services, or by the department for the blind.

52.3(9) The authority will calculate an applicant's gross income as follows: the total sales less the cost of goods sold plus any income from investments and from incidentals or outside operations or sources.

261—52.4(15) Decertification.

52.4(1) If the authority determines there is reasonable cause to believe a business does not comply with the requirements of the program, the authority shall provide written notice of the intent to revoke certification to the business. Notice shall be sent at least 20 days before decertification is effective.

52.4(2) The authority shall revoke certification of a TSB if the authority determines that a fraudulent practice related to the program has occurred. The authority or its representative may investigate allegations or complaints of fraudulent practices. A person is considered to have engaged in a fraudulent practice related to the program if the person does any of the following:

a. Knowingly transfers or assigns assets, ownership, or equitable interest in property of a business to a targeted group person primarily for the purpose of obtaining benefits afforded only to TSBs if the transferor would otherwise not be qualified for such programs.

b. Solicits and is awarded a state contract on behalf of a TSB for the purpose of transferring the contract if the person transferring or intending to transfer the work had no intention of performing the work.

c. Knowingly falsifies information on an application for the purpose of obtaining benefits afforded only to TSBs.

52.4(3) A TSB may be decertified if the authority sends a letter by first-class mail to the last-known address provided to the authority by the TSB and it is returned as undeliverable.

52.4(4) Eligibility to participate in the program continues until the authority issues a final decision regarding decertification of a TSB.

261—52.5(15) Waivers. A targeted small business may seek a satisfaction, performance, surety, or bid bond waiver from a state agency pursuant to Iowa Code section 12.44. A TSB must provide a sworn statement and documentation from surety companies verifying that the TSB is entitled to a waiver pursuant to Iowa Code section 12.44.

52.5(1) The authority reviews all requests for waivers. The authority may request information to assist the review process from the state agency requiring a bond. An applicant for a waiver pursuant to this rule and the agency requiring a bond will be notified of the decision in writing.

52.5(2) Waivers will be reviewed and renewed at the time of TSB recertification.

261—52.6(15) TSB procurement.

52.6(1) *TSB directory and purchases.* The authority compiles and regularly updates a TSB directory that contains a listing of TSBs that have been certified by the authority. Entities required to make purchases from TSBs pursuant to the Act utilize the directory to identify TSBs for purchases. By certifying a business, the authority does not represent that the business can perform any contract entered into by the business.

52.6(2) *Authority administration.* The authority may conduct a review of entities subject to the Act where there is evidence of little or no progress toward reaching its established TSB goal. The purpose of the review will be to identify the barriers encountered, evaluate the efforts taken to reach the goal, and provide available assistance.

52.6(3) *Reporting requirements.* The director of each state agency or department shall submit quarterly reports of TSB purchases to the authority in the format and by the due date specified by the authority. Reports provided to the department of education by community colleges, area education agencies, and school districts pursuant to Iowa Code section 73.17(2) shall be forwarded to the authority. Pursuant to Iowa Code section 73.17, the authority may require modifications from the agencies and departments based on the information reported pursuant to that Iowa Code section and this rule.

52.6(4) *Maintenance of records.* Entities subject to the Act shall develop a recordkeeping system that identifies and assesses TSB contract awards and progress in achieving a TSB goal. Records should demonstrate procedures adopted to comply with Iowa Code chapter 73 and this chapter and awards to TSBs. Records shall be available upon the request of the authority or the state auditor.

These rules are intended to implement Iowa Code sections 12.44 and 15.108(6) and chapter 73, subchapter III.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/16/24.

ARC 8260C

ECONOMIC DEVELOPMENT AUTHORITY[261]

Adopted and Filed

Rulemaking related to the targeted small business financial assistance program

The Economic Development Authority hereby rescinds Chapter 55, "Targeted Small Business Financial Assistance Program," Iowa Administrative Code, and adopts a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 15.106A.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 15.108(6) and 2013 Iowa Acts, House File 324.

Purpose and Summary

Pursuant to Executive Order 10 (January 10, 2023), the Authority hereby rescinds Chapter 55 and adopts a new chapter in lieu thereof. The chapter describes the policies and procedures by which the Authority provides financial assistance to targeted small businesses.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on July 24, 2024, as **ARC 8143C**. A public hearing was held on the following date(s):

- August 13, 2024
- August 15, 2024

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Authority Board on September 20, 2024.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Authority for a waiver of the discretionary provisions, if any, pursuant to 261—Chapter 199.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on November 20, 2024.

The following rulemaking action is adopted:

ITEM 1. Rescind 261—Chapter 55 and adopt the following **new** chapter in lieu thereof:

CHAPTER 55

TARGETED SMALL BUSINESS FINANCIAL ASSISTANCE PROGRAM

261—55.1(15) Targeted small business financial assistance program. The purpose of the program is to assist targeted group persons to establish or expand small business ventures in Iowa.

261—55.2(15) Definitions. As used in this chapter, unless the context otherwise requires:

“*Authority*” means the same as defined in Iowa Code section 15.102.

“*Disability*” means the same as defined in Iowa Code section 15.102.

“*Minority person*” means the same as defined in Iowa Code section 15.102.

“*Place of abode*” means a place of stay, permanent or for some time, for which consideration is paid.

“*Program*” means the targeted small business financial assistance program established pursuant to this chapter.

“*Review committee*” means a committee established by the authority to review program applications pursuant to subrule 55.3(8).

“*Service-disabled veteran*” means a veteran who provides written verification from the U.S. Department of Veterans Affairs or the U.S. Department of Defense of a disability that was incurred or aggravated in the line of duty in active military, naval, air, or space service.

“*Targeted group person*” means a minority person, woman, person with a disability, or service-disabled veteran who is either an Iowa resident or a resident of a contiguous state who lives within 50 miles of the targeted small business the person owns, operates, and actively manages.

“*Targeted small business*” or “*TSB*” means the same as defined in Iowa Code section 15.102.

“*Woman*” means any female 18 years of age or older.

261—55.3(15) Application and approval.

55.3(1) Application procedures. Application materials may be obtained from the authority.

55.3(2) Maximum funding. The maximum loan amount is \$50,000. The interest rate charged shall not exceed 5 percent per annum or be less than 0 percent per annum. A targeted small business shall not receive a loan under the program that provides more than 90 percent of the funding for a project. All applicants must invest at least 10 percent of the total project budget in cash.

55.3(3) Term. The term of a loan shall not exceed five years.

55.3(4) *Eligible uses of funds.* Program funds shall be used for legitimate business expenses, including but not limited to purchase of equipment and furnishings, inventory, purchase of and improvements to land and buildings and specific operating expenses.

55.3(5) *Ineligible uses of funds.* Program funds shall not be used to refinance existing debt. For the purposes of this subrule, existing debt does not include interim financing for allowable program purposes intended as a bridge loan obtained after the date a program loan is approved. Program funds shall not be used to facilitate financing of a project that would consist solely of relocation of an existing business within Iowa.

55.3(6) *Threshold criteria.* Applicants for funds under the program must meet the following minimum criteria before their applications will be considered complete and eligible for evaluation:

a. The business must be eligible for certification as a targeted small business pursuant to 261—Chapter 52 at the time of application. The authority will educate applicants about the benefits of such certification and encourage applicants to seek certification.

b. An applicant must be a resident of Iowa for at least six months to be eligible to apply for assistance. Applicants may be asked to provide necessary documentation to prove legal residency. An applicant who has not established a permanent place of abode in Iowa or who has not abandoned a permanent place of abode in another state shall be presumed to not be a resident of Iowa. A place of abode that is leased or rented shall be deemed permanent if leased or rented for a period of at least one year.

c. All applicants shall make a report regarding violations of law and address generation of solid or hazardous waste consistent with the requirements of Iowa Code section 15A.1(3).

55.3(7) *Submittal.* Applicants shall submit an application to the authority in the form and content prescribed by the authority.

55.3(8) *Review.*

a. Applications are reviewed for completeness. If additional information is required, the authority will notify the applicant. If the requested information is not provided by the deadline indicated in the notice, the application may be considered incomplete or ineligible.

b. The authority will establish a committee of at least three individuals to review all applications.

55.3(9) *Evaluation.* Applications are evaluated according to the following criteria:

a. Applicant credit score and outstanding liabilities.

b. Source(s) of the applicant's income.

c. Debt service coverage ratio.

55.3(10) *Negotiations.*

a. The authority reserves the right to negotiate the amount, term, interest rate, and other conditions of the loan prior to or after award.

b. The authority may decline to award funds to a business if there is a negative credit report (e.g., bankruptcy, foreclosure, tax liens, or unpaid or past due child support).

55.3(11) *Award decision.* If an application is approved by the review committee, the applicant business will receive an award letter that states the amount of the award, conditions of the award, any required security agreements, and the amount of monthly loan repayments. If an application is denied by the review committee, the applicant will receive a denial letter stating the reasons for denial.

55.3(12) *Reapplication.* An applicant whose application is denied by the review committee cannot resubmit an application for the program for 90 days from the date of the denial letter.

261—55.4(15) Monitoring.

55.4(1) The authority will monitor the recipient's records to ensure compliance with the terms of the award. The authority may request information on the condition of the business at any time during the life of the loan to determine the status of the project.

55.4(2) The authority may require a program recipient to consult with designated small business service providers for assistance with various aspects of the management and operation of the business.

55.4(3) If the authority determines that a borrower is in default, the authority may seek recovery of the loan plus interest or other penalties; negotiate alternative payment schedules; initiate, suspend or discontinue collection efforts; and take other action as the authority deems necessary.

261—55.5(15) Disbursement of funds. An approved applicant shall acknowledge and agree to the terms proposed by the authority prior to disbursement of funds. Requests for disbursement and loan documents shall be in the form and content specified by the authority.

These rules are intended to implement Iowa Code section 15.108 and 2013 Iowa Acts, House File 324.

[Filed 9/27/24, effective 11/20/24]

[Published 10/16/24]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 10/16/24.

ARC 8256C

UTILITIES COMMISSION[199]

Adopted and Filed

Rulemaking related to electronic filing

The Utilities Commission hereby rescinds Chapter 14, “Electronic Filing,” Iowa Administrative Code, and adopts a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 17A.3 and 476.2.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 17A.3 and 476.2.

Purpose and Summary

The Commission commenced this rulemaking under the provisions of Executive Order 10. The purpose of Chapter 14 is to inform the public of the Commission’s requirements, exceptions, and procedures for the electronic filing and service of pleadings; motions; evidence, including testimony; objections; comments; and other documents with the Commission.

The Commission is rescinding existing Chapter 14 and promulgating a new version of the chapter with updated language to better reflect current Commission procedures, to remove unnecessary and unneeded language and provisions, and to reduce the number of restrictive terms.

The Commission issued an order commencing rulemaking on September 18, 2024. The order is available on the Commission’s electronic filing system (EFS), efs.iowa.gov, under Docket No. RMU-2023-0014.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on July 10, 2024, as **ARC 8106C**. A public hearing was held on the following date(s):

- August 21, 2024
- September 4, 2024

The August 21, 2024, public hearing was attended by the Office of Consumer Advocate (OCA), a division of the Iowa Department of Justice; Interstate Power and Light Company (IPL); MidAmerican Energy Company (MidAmerican); Black Hills/Iowa Gas Utility Company, LLC d/b/a Black Hills Energy (Black Hills); Iowa American Water Company (Iowa American); and Iowa Farm Bureau Federation

(Farm Bureau). The September 4, 2024, public hearing was attended by OCA, IPL, MidAmerican, Black Hills, and Iowa-American.

Attending stakeholders opposed certain proposed changes to the rules regarding the timing of filings in the Commission's electronic filing system and the official filing date of such filings. Farm Bureau also suggested changes to subrules 14.4(3) and 14.14(2). Otherwise, the commenting stakeholders did not oppose the Commission's adoption of Chapter 14.

The Commission received written comments from OCA and Farm Bureau. OCA expressed its support for the proposed version of Chapter 14, and Farm Bureau suggested that portions of subrules 14.4(3) and 14.14(2) were unclear and should be modified.

The Commission made three changes from the Notice. First, in rule 199—14.9(17A,476), the Commission had proposed to remove existing language to recognize that a party may upload a document in EFS at any time of the day and to reflect that the official filing date would be the date of upload. The commenting stakeholder uniformly opposed this change and requested the Commission reinsert the current rule 199—14.9(17A,476) language, which the Commission did in this rulemaking. Next, Farm Bureau requested subrules 14.4(3) and 14.14(2) be revised to remove certain unclarity, and after working with stakeholders, the Commission proposed revised language in both subrules, to which all other stakeholders either agreed or did not oppose.

Adoption of Rulemaking

This rulemaking was adopted by the Commission on September 18, 2024.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

No waiver provision is included in the amendments because the Commission has a general waiver provision in rule 199—1.3(17A,474,476) that provides procedures for requesting a waiver of the rules in this chapter.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on November 20, 2024.

The following rulemaking action is adopted:

ITEM 1. Rescind 199—Chapter 14 and adopt the following **new** chapter in lieu thereof:

CHAPTER 14 ELECTRONIC FILING

199—14.1(17A,476) Purpose. The purpose of these rules is to establish an electronic filing requirement, to identify exceptions to the electronic filing requirement, and to specify procedures regarding electronic filing and service of documents filed with or issued by the commission.

199—14.2(17A,476) Scope and applicability of electronic filing requirement. Electronic filing is mandatory, unless specifically excepted by these rules or the commission. The commission will accept filings electronically pursuant to the rules in this chapter and the commission's published standards for electronic information, available on the commission's website (iuc.iowa.gov) or from the commission's customer service bureau, or as delineated in the commission order or other official statement requiring those filings.

199—14.3(17A,476) Definitions. Except where otherwise specifically defined by law:

"Accepted for filing" ordinarily means a filing will be published in the commission's electronic filing system. Certain documents will be accepted for filing without being published in the commission's electronic filing system. A filing that has been accepted for filing can be rejected if found not to comply with a commission rule or order.

"Electronic filing" means the process of transmitting a document or collection of documents via the Internet to the commission's electronic filing system for the purpose of submitting the document for commission consideration.

"Electronic filing system" or *"EFS"* means the system used by the commission's customer service bureau to accept and publish documents filed electronically, and that allows the public and parties to view most documents filed with or issued by the commission.

"Guest user" means a person who uses EFS without a user ID and password. Guest users are able to view and file documents via EFS.

"Publish" means to make a document available for public viewing or download by uploading it to EFS.

"Registered user" means a person who has complied with the commission's requirements in rule 199—14.6(17A,476) to obtain a user ID and password in order to submit filings for the commission's consideration through EFS.

199—14.4(17A,476) Exceptions. The following types of filings are not subject to the electronic filing requirement:

14.4(1) Filings made by any person who has been excused from the requirement by commission order granting a request for permission to file paper documents. Upon request, the commission may issue an order granting permission to file paper documents and specifying the number of paper copies to be filed.

14.4(2) Informal consumer complaints. Consumers may submit complaints electronically by using the online complaint form available on the commission's website or by email; on paper by mail or facsimile; or by personally delivering the written complaint to the commission's customer service bureau. Informal consumer complaint files are available for public inspection from the commission's customer service bureau. An informal complaint file will be made available for public viewing in EFS, to the extent reasonable.

14.4(3) Written objections to applications for electric transmission line franchises, pipeline permits, or hazardous liquid pipeline permits. Written objections in these cases may be submitted through EFS or may be submitted on the commission's website, by email, by post, or in person. Electronic filing of objections is preferred. A suggested objection form is available on the commission's website.

14.4(4) Comments from persons in any other proceeding in which comments from the public are permitted. Persons may submit comments through EFS pursuant to these rules, by using any applicable online comment form available on the commission's website, by email, or by letter. Comments from persons will ordinarily be published in EFS.

199—14.5(17A,476) Electronic filing procedures and formats. Electronic documents shall be filed in accordance with the following procedures and formats:

14.5(1) Persons who make infrequent filings with the commission may file as a guest user. Persons who make regular filings with the commission may register to obtain a user ID and password pursuant to registration procedures specified in rule 199—14.6(17A,476). The commission may direct an infrequent filer to become a registered user.

14.5(2) Electronic filings are made by uploading a document or collection of documents into EFS. Emailing a document to the commission does not constitute filing the document.

14.5(3) A filer should provide all necessary information when electronically filing a document.

14.5(4) Electronically filed documents are to be named in a way that accurately describes the contents of each document.

14.5(5) All documents are to be formatted in accordance with the commission's standards for electronic information, which are available on the commission's website or from the commission's customer service bureau.

14.5(6) Any text-based document that has been scanned for electronic filing should be full-text searchable to the extent that is reasonably possible.

14.5(7) Spreadsheets and databases included in filings shall include all cell formulae and cell references. Spreadsheets with macros will not be accepted. Where a filer requests confidential treatment of cell formulae and cell references or any other information included in a spreadsheet or database, the filer may file a request for confidential treatment and two versions of the document: a public version of the document with the cell formulae deactivated and other confidential information redacted and a version not for publication containing live formulae and the information for which confidential treatment is requested.

14.5(8) Hyperlinks and other navigational aids may be included in an electronically filed document. Each hyperlink should contain a text reference to the target of the link. Although hyperlinks may be included in a document as an aid to the reader, the material referred to by the hyperlinks is not considered part of the official record or filing unless the referenced material itself is filed (e.g., hyperlinking a document previously filed in EFS). Hyperlinks to cited authority do not replace standard citation format for constitutional citations, statutes, cases, rules, or other similarly cited materials.

14.5(9) EFS will display an "Upload Complete" notice when the upload of the filing is completed. If the "Upload Complete—Filing Submitted" notice does not appear, the filer may contact the commission's customer service bureau during regular business hours to determine the status of the filing.

14.5(10) After reviewing the filing, the commission's customer service bureau will either accept or reject the filing. If the filing is accepted, the document (if not confidential) will be published in EFS, and an electronic file stamp indicating the docket number(s) and date of filing will be added to the published document. A Notice of Electronic Filing containing a link to the filing will be sent by email to the filer and to all parties identified on the service list as able to receive electronic service. From the link, the recipient of the notice can view the filing. Where a document is accompanied by a request for confidential treatment, the filing will include the public version of the document, in which information identified as confidential has been redacted. Where a filing consists only of a confidential document, such as a response to a commission survey or other inquiry, that the commission has deemed confidential pursuant to an order requiring the response, the document will not be published. Acceptance of a document for filing is not a final determination that the document complies with all commission requirements and is not a waiver of such requirements. If a filing is rejected, a Notice of Rejection explaining why the filing has been rejected will be sent by email to the filer, or the filer will be contacted by other appropriate means.

14.5(11) Errors. If a filer discovers an error in the electronic filing or publishing of a document, the filer should contact the commission's customer service bureau as soon as possible. The customer service bureau will review the situation and advise the filing party how the error will be addressed by the customer service bureau and what further action by the filer may be necessary, including a revised filing with the commission. Ordinarily, any modification to an EFS filing will require a revised filing in EFS. If errors in the filing or publishing of a document are discovered by the commission's customer service bureau, commission staff will ordinarily notify the filer of the error and advise the filer of what further action, if any, is necessary to address the error.

14.5(12) Electronic documents and the hearing process. Any prefiled testimony or exhibit that is altered or corrected at the hearing in any way and admitted into evidence, and any paper documents that are newly admitted into evidence as exhibits at the hearing, must be electronically filed at the earliest opportunity but no later than three business days after the material is admitted into evidence.

199—14.6(17A,476) Registration. A person may become a registered user by completing the registration form, which is available on the commission’s website, and obtaining a user ID and password. If a user believes the security of an existing password has been compromised, the user should change the password immediately and may contact the commission’s customer service bureau.

199—14.7(17A,476) Electronic record. The official agency record in any proceeding is the electronic record maintained in EFS and any paper filings accepted by the commission that are not stored in electronic form.

199—14.8(17A,476) Maps, plan and profile drawings, and other oversized documents. Any map, plan and profile drawing, or oversized document that is to be filed with the commission should be electronically filed as a PDF (Portable Document Format) or such electronic format as designated by the commission. If the map, drawing, or oversized document cannot be printed on 11- by 17-inch or smaller-sized paper in legible and usable form, as determined by the commission, the original and four paper copies of each map, drawing, or other document filed pursuant to this rule should also be filed unless more copies are directed by commission order or request. Maps and other documents should be drawn to a scale appropriate for the level of detail to be shown. However, if the map, drawing, or other document is not electronically filed, then the number of paper copies filed is governed by other applicable rules, including the “hearings” rule in 199—Chapter 7, which concerns the required number of copies for evidence introduced at hearing, and 199—Chapter 26, which contains additional requirements regarding the number of paper copies of minimum filing requirements required to be filed in rate and tariff proceedings.

199—14.9(17A,476) When electronic filings can be made; official filing date. Unless otherwise ordered, an electronic filing can be made at any time outside of any maintenance periods during which the system will not be available. The Notice of Electronic Filing generated when the document is accepted for filing will record the date of the filing of the document, which will be the official filing date of the document. Documents uploaded into EFS by 3:30 p.m. central time on a business day, if accepted for filing, will be considered filed on that day. Documents uploaded into EFS after 3:30 p.m. central time on a business day or at any time on a nonbusiness day may, if accepted, be considered filed on the next business day.

199—14.10(17A,476) EFS unavailability; technical difficulties. Scheduled EFS maintenance and unscheduled EFS outages that are expected to last more than 30 minutes will be posted on the commission’s website. It is the responsibility of the filer to ensure that a document is timely filed to comply with jurisdictional deadlines. A technical failure of EFS, the filer’s own computer equipment, or any other part of the filing system will not excuse the filer from compliance with a jurisdictional filing deadline. If a filer is not able to meet a nonjurisdictional deadline because of a technical failure, the filer should, by the earliest available conventional or electronic means, file the document and seek appropriate relief from the commission.

199—14.11(17A,476) Documents containing confidential material. Confidential documents will not be published in EFS. When filing a document containing confidential information, a person shall file one public version of the document with the confidential information redacted according to the commission’s standards for electronic information and one version of the document containing the confidential information. The two versions of the document should be named according to the following convention: “Document Title—Public” and “Document Title—Confidential.” It is the responsibility of the person submitting a public version of the electronic document to take appropriate measures to ensure that any embedded information for which confidential treatment is sought is nonviewable, nonsearchable, and nonreversible. Each page of the confidential version of the document shall be marked in a way that identifies it as belonging to the confidential version of the document. The confidential material itself is to be highlighted or otherwise distinguished on the page to identify what specific information is confidential. A filing including a document the filer asserts contains confidential information is also to

include a separate document containing the request for confidential treatment pursuant to 199—Chapter 1. Documents that the filer asserts contain confidential information will not be electronically served by EFS, as provided in 199—Chapter 14.

199—14.12(17A,476) Signatures.

14.12(1) *Filings by registered users.* The use of a user ID and password in accordance with the registration procedures specified in rule 199—14.6(17A,476) constitutes the filer's signature. Filers should use “/s/” followed by the signer's name to indicate a signature where applicable. All pleadings shall include a signature block containing the signer's name, title, address, email address, and telephone number.

14.12(2) *Filings by guest users.* The personal information provided to submit a filing as a guest user constitutes the filer's signature. Filers should use “/s/” followed by the signer's name to indicate a signature where applicable. All pleadings should also include a signature block containing the signer's name, title, address, email address, and telephone number.

199—14.13(17A,476) Original documents. When a commission rule directs the filing of an original document not prepared by the filer or the party on whose behalf the document is filed, such as an invoice or other document, the filer should scan the original document and file the scanned document in EFS or request advance commission approval of other arrangements. The filer must retain the original document for a period of two years or until the conclusion of the proceeding or the conclusion of an appeal, whichever is greater.

199—14.14(17A,476) Electronic service.

14.14(1) *Service on parties able to receive electronic service.* Unless otherwise provided by commission rule or order, whenever a document is filed electronically, a Notice of Electronic Filing will be generated and sent to the filer and to representatives of the other parties who are able to receive electronic service and who are on the service list. This notice will constitute valid service of electronically filed documents and commission orders on parties accepting electronic service. The notice will include a service list providing names, addresses, and email addresses of the persons who were sent the notice. No additional proof or certificate of service is necessary in matters in which all parties are able to receive electronic service. It is the responsibility of the filer to review the notice to ensure that all parties have been provided notice. All parties are responsible for ensuring that their email accounts are monitored regularly and that email notices sent to the account are opened in a timely manner.

14.14(2) *Service on parties for whom electronic service is not available.* The service list in each proceeding will be available in EFS. The list will identify the representatives for each party and will also indicate the parties for whom electronic service is not available. A filer is to serve a paper copy of any electronically filed document on parties entitled to paper service under the “general information” rule in 199—Chapter 7 unless the parties agree to other arrangements. The date of service is the day when the document served is deposited in the United States mail or overnight delivery, is delivered in person, or otherwise as the parties may agree. A party serving a paper copy of any electronically filed document on a person for whom electronic service is not available is to file a certificate of service stating the manner in which service on such person was accomplished.

14.14(3) *Service of commission-generated documents.* Orders issued by the commission will be electronically filed. EFS will electronically transmit notice of posting of orders to all parties on the service list that are able to receive electronic service. This notice will constitute valid service of the order. The commission's customer service bureau will mail paper copies of orders to parties who are not able to receive electronic service and to others as ordered.

14.14(4) *Exceptions.* Electronic service through EFS to parties other than the consumer advocate division of the department of justice is not to be used to serve a document that:

- a. The filer asserts contains confidential material, or
- b. Initiates a proceeding, such as a complaint or application, except for orders opening inquiries, investigations, or rulemaking proceedings, or other similar proceedings where the commission has an electronic service list on file.

14.14(5) *Changes to service list.* Filers wishing to change information on the service list may contact the commission's customer service bureau. Other changes to the service list, such as a withdrawal of appearance or substitution of counsel, may be requested by means of an appropriate filing. These rules are intended to implement Iowa Code sections 17A.4 and 476.2.

[Filed 9/26/24, effective 11/20/24]

[Published 10/16/24]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/16/24.

ARC 8257C

UTILITIES COMMISSION[199]

Adopted and Filed

Rulemaking related to crossing of railroad rights-of-way

The Utilities Commission hereby rescinds Chapter 42, "Crossing of Railroad Rights-of-Way," Iowa Administrative Code, and adopts a new chapter with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code sections 17A.3, 476.1 to 476.1B and 476.27.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code sections 476.1 to 476.1B and 476.27.

Purpose and Summary

The purpose of this chapter is to execute Iowa Code section 476.27 by providing backstop terms and conditions for crossing railroad rights-of-way by public utilities.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on July 10, 2024, as **ARC 8103C**. A public hearing was held on the following date(s):

- July 30, 2024
- August 6, 2024

The Office of Consumer Advocate, a division of the Iowa Department of Justice, and the Iowa Communications Alliance participated in the public hearings. Both parties expressed support for adopting the version of Chapter 42 proposed by the Commission without modification.

The Office of Consumer Advocate, a division of the Iowa Department of Justice, filed written comments supporting adoption of the version of Chapter 42 proposed by the Commission without modification.

One change from the Notice has been made. Proposed rule 199—42.1(476) referenced the 2023 edition of the American Railway Engineering and Maintenance-of-Way Association Manual for Railway Engineering. That reference has been updated to the 2024 edition.

Adoption of Rulemaking

This rulemaking was adopted by the Commission on September 20, 2024.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

No waiver provision is included in the amendments because the Commission has a general waiver provision in rule 199—1.3(17A,474,476) that provides procedures for requesting a waiver of the rules in this chapter.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on November 20, 2024.

The following rulemaking action is adopted:

ITEM 1. Rescind 199—Chapter 42 and adopt the following **new** chapter in lieu thereof:

CHAPTER 42
CROSSING OF RAILROAD RIGHTS-OF-WAY

199—42.1(476) Definitions. The following words and terms, when used in these rules, have the meanings set forth in Iowa Code section 476.27: “crossing,” “direct expenses,” “electric transmission owner,” “facility,” “public utility,” “railroad” or “railroad corporation,” “railroad right-of-way,” and “special circumstances.”

In addition, as used in this chapter, the following definitions apply:

“*AREMA Manual*” means the American Railway Engineering and Maintenance-of-Way Association Manual for Railway Engineering—2024, which is a source of generally accepted engineering practices for the railway industry.

“*CFR*” means the Code of Federal Regulations, which contains the general administrative rules adopted by federal departments and agencies, in effect as of May 20, 2024, unless a separate effective date is identified in a specific rule.

“*Commission*” means the Iowa utilities commission.

“*Complainant*” means a person who complains to the commission by written complaint regarding any of the issues identified in Iowa Code section 476.27(2) or these rules.

“*Petitioner*” means a person who files a written petition with the commission seeking a determination of special circumstances pursuant to Iowa Code section 476.27(4).

“*Respondent*” means a person against whom a complaint or petition is filed.

“*Small utility*” means a public utility and all affiliates of the public utility that collectively serve fewer than 20,000 customers. For purposes of this definition, a “customer” means the party responsible for payment of the utility services. When the specification exhibit is filed with the railroad, the small utility will certify on the specification exhibit that it meets the definition of a small utility as contained in this rule. The specification exhibit will also state that at such time that the small utility no longer meets the small utility definition, it will have an affirmative duty to so notify the railroad.

199—42.2(476) Applicability and purpose. These rules provide terms and conditions for the crossing of railroad rights-of-way by public utilities. However, these rules shall not prevent a railroad and public utility from negotiating other terms and conditions applicable to a crossing or agreeing to a different

dispute resolution mechanism than that provided for in Iowa Code section 476.27 and these rules. These rules do not apply to longitudinal occupancy of a railroad right-of-way, but only to the crossing of a railroad right-of-way.

199—42.3(476) General notice and specification exhibit requirements and payment of fee.

42.3(1) *Notice and exhibit.* Any time a public utility intends to construct a crossing across a railroad right-of-way, the utility shall submit to the railroad a notification of intent to construct, along with a specification exhibit that shows the location of the crossing and the railroad's property, tracks, and wires that the public utility's facilities will cross. The notice and exhibit shall be submitted to the railroad by certified mail, return receipt requested. The one-time standard crossing fee of \$750, unless otherwise agreed to by the railroad and public utility, shall accompany the notice and exhibit. The public utility shall use its best efforts to submit the specification exhibit on a form provided or approved by the railroad. The specification exhibit constitutes the public utility's warranty that the public utility facilities that are the subject of the exhibit will be constructed and installed as shown on the exhibit. Railroad Crossing Specification Exhibit forms are available on the commission's website, iuc.iowa.gov.

42.3(2) *Exhibit—overhead wireline crossings.* For overhead wireline crossings, the specification exhibit shall contain, at a minimum, the location of the poles supporting the crossing span and adjoining spans on each side of the crossing span on the proposed facilities; the number, kind, and size of wires; and the clearance between the facilities and any existing railroad tracks, wires, or fiber-optic lines.

42.3(3) *Exhibit—underground crossings.* For underground crossings, the specification exhibit shall contain, at a minimum, the number, kind, and size of wires, pipes, and conduit and casing to be used; the commodity conveyed; and the depth to which the public utility facilities will be placed below the base of the rail track and at other locations on the right-of-way. Multiple wires to be contained within a single conduit may be combined on a single exhibit and notice of intent to construct. Both cased and uncased natural gas pipeline crossings shall be provided for on the specification exhibit form or forms.

42.3(4) *Authorization to commence construction.* After 35 days from the mailing of the notice, specification exhibit, and fee, the public utility, absent a claim of special circumstances or objection from the railroad that the information contained in the specification exhibit is inadequate or incomplete, shall be deemed to have authorization to commence construction of the facilities that are the subject of the specification exhibit. In the event the public utility does not commence construction within 120 days from the mailing of the notice or any changes to the specification exhibit, whichever is later, the notice shall expire and the fee may be retained by the railroad. If the public utility subsequently desires to proceed with construction of the facilities subject to the notice, the public utility must again comply with the notice, specification exhibit, and fee requirements of these rules.

42.3(5) *Crossing notice and payment of flagging costs.* In addition to any other required notice, a public utility, except for emergency repair or maintenance, shall provide the railroad written notice at least ten days prior to commencing any construction, maintenance, or repair of facilities within the railroad's right-of-way. Such notice is to enable the railroad to make any appropriate flagging arrangements. The public utility shall reimburse the railroad for actual flagging expenses within 30 days of receipt of a bill for flagging services.

42.3(6) *Securing damages—special circumstances.* Pending a commission resolution of a claim of special circumstances raised in a petition filed by the railroad pursuant to Iowa Code section 476.27(4) and subrule 42.18(2), a public utility may, upon compliance with these rules and securing the payment of an amount sufficient for the removal of any facilities constructed by the public utility in a manner approved by the commission, proceed with construction unless the commission intervenes to prevent construction pursuant to Iowa Code section 476.27(6).

42.3(7) *Inductive interference study.* If the railroad reasonably determines through its initial review of the specification exhibit and engineering analysis that a proposed public utility facility has a material possibility of posing an induction problem with railroad property, the public utility, if it wishes to proceed with the facility, shall cause a formal inductive interference study to be performed by a qualified engineer approved by the railroad. The public utility shall make and pay for any modifications to the proposed facility, or to the railroad's property, that are necessary to ensure safe and reliable operations of

the railroad's property that are recommended by the qualified engineer. No public utility facility that has undergone an inductive interference study pursuant to this subrule shall be energized until the railroad has had an opportunity to conduct any appropriate tests to ensure that, after the facility is energized, there will not be any interference with the operation of the railroad's property. Any appropriate tests shall be conducted by the railroad within 30 days after receipt of a notice from the public utility that the facility is ready to be energized.

199—42.4(476) Emergency notice and repairs.

42.4(1) *Notice.* In the event a public utility or railroad needs to perform emergency or nonroutine maintenance or repair within a railroad right-of-way and the maintenance or repair may affect the operations of the other entity, immediate notification of the maintenance or repair being performed shall be given.

42.4(2) *Notification plan filing.* Each railroad and public utility with a facility crossing railroad right-of-way shall establish, and file with the commission, a mechanism or plan for receiving emergency notifications 24 hours per day, seven days per week.

42.4(3) *Scope of emergency work and reimbursement of expenses.* Unless permission from the affected railroad or public utility has been received, the railroad and public utility may only perform maintenance or repair work of their own respective property. If the emergency maintenance or repair performed by the railroad or public utility causes reasonable expenses to be incurred by the other entity, those reasonable expenses shall be reimbursed.

199—42.5(476) Relocation of public utility facilities.

42.5(1) *Standard for relocation.* The railroad may require that the public utility, at the public utility's expense, relocate facilities on railroad right-of-way whenever such relocation is necessary to accommodate railroad operations. The decision that relocation is required is made solely by the railroad, although the railroad may not act arbitrarily or unreasonably. The public utility shall not have to pay a standard crossing fee for such relocations.

42.5(2) *Completion of relocation.* In the event relocation of facilities is required, the relocation shall be to a location mutually agreed upon by the railroad and utility, within the railroad right-of-way. The relocation shall be completed within a reasonable period of time.

42.5(3) *Statement of reasons.* Upon the request of the public utility, the railroad shall provide within 15 days a statement or other supporting documentation indicating the operational reasons for requiring relocation of facilities.

199—42.6(476) Engineering standards for electric and communications lines. These engineering standards apply to crossings that do not involve special circumstances such that additional or more stringent engineering standards may be warranted. The determination of such additional or more stringent standards will be determined on a case-by-case basis, according to the procedures in rule 199—42.18(17A,476), depending on the facts and circumstances associated with the particular crossing.

42.6(1) *General.*

a. Except as provided for in this chapter, electric and communications lines crossing railroads shall be constructed in accordance with 199—Chapter 25, the Iowa electrical safety code.

b. Crossings should be made as near as possible at an angle of 90 degrees to the railroad tracks, but in no event shall any crossing be at less than a 60-degree angle to the railroad track.

c. Aboveground facilities at road or pedestrian crossings shall be located or constructed in a manner that minimizes interference with lines of sight for observing oncoming trains.

42.6(2) *Additional requirements for overhead crossings.*

a. In determining the line height needed to meet the clearance requirements of the Iowa electrical safety code, the height of a rail car shall be assumed to be 23 feet.

b. Electric and communications lines shall be installed with at least four feet of clearance above overhead railroad signal and communications lines.

c. The perpendicular distance of poles from the centerline of the tracks shall not be less than the largest of the following:

(1) Unguyed poles shall be located a minimum distance equal to the height of the pole above the ground line plus ten feet. If guys are installed, they shall be placed in a manner that would prevent the pole from leaning or falling in the direction of the tracks.

(2) Fifty feet near straight tracks, except for industry track where ten feet is permitted. If the pole is located adjacent to a segment of curved track, the clearance shall be increased by 1.5 inches per degree of track curvature.

(3) Towers for electric lines capable of operating at 34,500 volts or more shall not be located on railroad right-of-way.

d. Poles shall be located a minimum distance from overhead railroad signal or communications lines equal to the height of the pole above ground line, or poles must be guyed at a right angle away from such lines.

e. Crossings shall not be installed under or within 500 feet of a railroad bridge, or 300 feet from the centerline of a culvert or switch area.

42.6(3) *Additional requirements for underground crossings.*

a. The minimum depth below the base of the rail shall be 4.5 feet except for fiber-optic cables, which shall be 5.0 feet.

b. The minimum depth at other locations on the right-of-way shall be:

- (1) 5.0 feet for fiber-optic cables;
- (2) 4.0 feet for conductors operating at more than 750 volts;
- (3) 3.0 feet for all other lines.

c. Crossings shall not be installed within 50 feet of the end of a railroad bridge, the centerline of a culvert, or a switch area.

d. Casings must extend at least 30 feet from the centerline of the nearest track, measured at a right angle, except that casings for electrical conductors operating at more than 750 volts shall extend the full width of the right-of-way. At burial depths of less than 15 feet below the track, the casing material shall be steel or rigid metal conduit. At depths of 15 feet or more, polyvinyl chloride (PVC) casing pipe may be used.

e. Except for the track and ballast area, warning tape shall be installed one foot below ground level over conductors operating at more than 750 volts, except that tape is not required for lines installed using horizontal directional drilling.

f. Bored crossings shall not be installed using water jetting or other methods that might leave cavities beneath a railroad embankment. Horizontal directional drilling techniques that use drilling mud are permitted. Pits for boring or drilling crossings shall be beyond the limits of the railroad embankment.

g. Unless otherwise authorized by the railroad, a railroad representative must be present during installation of buried crossings if there are underground railroad signal lines in the vicinity of the crossing.

199—42.7(476) Engineering standards for pipelines. These engineering standards apply to crossings that do not involve special circumstances such that additional or more stringent engineering standards may be warranted. The determination of such additional or more stringent standards will be made on a case-by-case basis, according to the procedures in rule 199—42.18(17A,476), depending on the facts and circumstances associated with the particular crossing.

42.7(1) *General.*

a. Except as provided for in this chapter, pipelines crossing railroads shall be constructed in accordance with Chapter 1, Part 5, "Utilities," of the AREMA Manual.

b. For pipelines subject to 49 CFR Part 192, "Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards," or 49 CFR Part 195, "Transportation of Hazardous Liquids by Pipeline," the appropriate federal standard shall control for pipeline marker signs, valves, corrosion control, welding and weld testing, and pressure testing. The design stress level in such pipelines shall not exceed that permitted by the appropriate federal standard.

c. Polyethylene (PE) pipe may be used as carrier pipe for natural gas pipelines. PE and PVC pipe may be used as carrier pipe for water and wastewater. Such pipe shall be manufactured of materials approved for its intended use by an appropriate standards organization.

d. Slip jointed carrier pipe may be used only for encased water or wastewater pipelines, and the ends of such casings shall be oriented such that drainage from any internal leakage will not endanger the railroad embankment.

e. Casings of material other than steel may be used with railroad company approval.

f. Cathodic protection test boxes located on a railroad right-of-way shall be attached to casing vents or installed flush with the ground surface.

42.7(2) Installation methods.

a. Pipe shall be installed using boring, drilling, or jacking methods. Open cut crossings are permitted only with the specific authorization of the railroad company.

b. Pits for boring or jacking shall not disturb the railroad embankment and shall be located at least 30 feet from the track centerline where practical. Pits shall be of the minimum size necessary.

c. Bored crossings shall not be installed using water jetting or other drilling methods that might leave cavities beneath a railroad embankment. Horizontal directional drilling techniques that use drilling mud are permitted.

d. Pipe or casing shall be installed with at least one foot of separation from any other pipe or wire in the right-of-way.

e. When boring for pipe greater than 20 inches in diameter is proposed, and the pipe would be installed less than ten feet below the base of the rail, if the railroad has knowledge of soil conditions in the vicinity that could lead to deterioration of track support if the soil is disturbed, the railroad company may require that a geotechnical study be performed by the public utility to determine whether the proposed crossing site is undesirable or requires special construction methods or monitoring.

f. For unusually large pipeline crossings that do not involve special circumstances, or for crossings where geotechnical study has identified potentially destabilizing soil conditions, the railroad company may require that a railroad representative be present during installation and may also require the presence of a survey crew to monitor the tracks for any change in alignment.

199—42.8(476) Liability. Each railroad and public utility shall maintain and repair its respective property within the railroad right-of-way, and the railroad and public utility shall bear responsibility for each person's own acts and omissions, except the public utility shall be responsible for any bodily injury or property damage that typically would be covered under a standard railroad protective liability insurance policy.

199—42.9(476) Insurance.

42.9(1) Unless otherwise agreed upon by the railroad and public utility, the public utility shall maintain, or cause to be maintained, the following minimum insurance coverage with respect to each railroad crossing:

a. General public liability insurance with limits of not less than \$500,000 for injury or death of a single person, or not less than \$1 million for any one accident, and not less than \$250,000 per accident for property damage. The exclusion or limitations for railroads shall be removed.

b. Comprehensive automobile liability insurance with limits of not less than \$500,000 for injury or death of a single person, or not less than \$1 million for any one accident, and not less than \$250,000 for property damage.

c. Excess liability coverage with limits of not less than \$5 million, except that the required limits shall be \$1 million for small utilities for railroad crossings by facilities other than gas or hazardous materials pipelines.

d. Railroad protective liability insurance with a combined single limit of \$4 million per occurrence and \$6 million aggregate, except that the required limits shall be a combined single limit of \$2 million per occurrence and \$4 million aggregate for small utilities for railroad crossings by facilities other than gas or hazardous materials pipelines. Such coverage shall be required only during the period of

construction, repair, or replacement of the facilities and may be provided by a blanket railroad protective liability insurance policy provided that the coverage, including the coverage limits, applies separately to each individual crossing on each individual railroad.

42.9(2) The coverage in paragraphs 42.9(1) “a” through “d” must be by blanket insurance policies covering other property or risks, or self-insurance. In the event the public utility desires to self-insure, it must maintain a minimum long-term rating of A- and net assets of not less than \$100 million, unless the railroad agrees to different amounts. If the public utility’s long-term rating is lowered below an A- rating, the public utility will provide commercial insurance as required in this rule and will notify the railroad that its long-term rating was lowered below A-.

42.9(3) The coverage in paragraphs 42.9(1) “a” through “d” must be in place prior to the commencement by the public utility of any work within the railroad’s right-of-way in order to secure payment for any damages for which the public utility bears responsibility.

42.9(4) Before commencing construction of any facility, the public utility must provide to the railroad proof that the public utility has procured the insurance coverage as required in this rule.

199—42.10(476) Removal of equipment. Upon completion of any facility, the public utility shall remove, or cause to be removed, all tools, equipment, or other property used in the construction and, if railroad property was moved or disturbed, restore that property to the same condition it was in prior to being moved or disturbed.

199—42.11(476) Assignment. The public utility may assign or otherwise transfer any rights to cross a railroad right-of-way to any financially responsible entity controlled by, controlling, or under common control with the public utility or to any entity into or with which the public utility is merged or consolidated or that acquires ownership or control of all or substantially all of the transmission assets of the public utility. Notice of the assignment or transfer shall be given to the railroad within 30 days. No other transfer or assignment may take place without the written permission of the railroad, which permission shall not be unreasonably withheld.

199—42.12(476) Prohibition against mechanic’s liens. The public utility shall not create, permit, or suffer any mechanic’s lien or other lien of any kind or any nature to be created or enforced against the railroad’s property for any work performed by the public utility in connection with its facilities that are located in the railroad’s right-of-way. The railroad shall not create, permit, or suffer any mechanic’s lien or other lien of any kind or any nature to be created or enforced against the public utility’s property located in the railroad’s right-of-way for any work performed by the railroad in connection with the railroad’s facilities.

199—42.13(476) Taxes. The public utility shall promptly pay or discharge all taxes and charges levied upon its facilities located in the railroad’s right-of-way. Where any such tax or charge may not be separately made or assessed to the public utility, but is included in the taxes or charges assessed to the railroad, the public utility shall pay to the railroad an equitable portion of such taxes determined by the value of the public utility’s facilities located on the railroad’s right-of-way as compared with the entire value of the railroad property.

199—42.14(476) Protection of signal systems. Prior to penetrating the surface of any railroad right-of-way, the public utility shall contact the railroad to determine whether any of the railroad’s signal systems are located in the area. If signal systems are located in the area, the public utility, at its expense, shall arrange for a cable locator and make arrangements for relocation or other protection of the signal system. The public utility shall also contact Iowa One Call for locating other underground facilities and shall comply with all other applicable statutes, regulations, and rules pertaining to such underground facilities.

199—42.15(476) Safety regulations. The public utility shall ensure compliance with all applicable local, state, and federal safety rules and regulations during the time any work is being performed on a

facility within the railroad's right-of-way. Any personal injury arising during work being performed on a facility shall be promptly reported by the public utility to the railroad.

199—42.16(476) Recording. The public utility, at its own expense, may record a memorandum of its rights pursuant to Iowa Code section 476.27 and these rules. A legal description of the crossing that has been approved by both the railroad and public utility shall be attached to the memorandum. Upon termination of the public utility's rights, the public utility shall file an appropriate document to evidence such termination.

199—42.17(17A,476) Complaints and petitions for relief—general information. These rules are promulgated under Iowa Code chapter 17A and section 476.27 as guides for procedures when railroads or public utilities file with the commission complaints regarding crossings pursuant to Iowa Code section 476.27(2) "a"(9) or petitions for relief pursuant to Iowa Code section 476.27(4). The purpose of these rules is to facilitate the transaction of business before the commission and to promote the just resolution of controversies. Any procedural rules in 199—Chapter 7 that are in conflict with these rules do not apply to contested cases under this chapter.

199—42.18(17A,476) Complaints and petitions for relief.

42.18(1) Complaints. A railroad or public utility that has a complaint regarding any of the issues identified in Iowa Code section 476.27(2) that cannot be resolved without intervention by the commission may file a complaint with the commission.

42.18(2) Petitions for relief. A railroad or public utility that believes special circumstances exist for a particular crossing pursuant to Iowa Code section 476.27(4) may file a petition for relief with the commission if the railroad and the public utility have been unable to resolve their differences without intervention by the commission.

42.18(3) Information to be filed. The written complaint or petition should include the following information:

- a. The name, address, telephone number, and contact person for the complainant or petitioner and the complainant's or petitioner's attorney, if any;
- b. The basis for the commission's jurisdiction over the matter;
- c. A statement of the complainant's or petitioner's position and a detailed discussion of the facts that support the complainant's or petitioner's position, including a description of the issues involved, why special circumstances exist for the particular crossing, the resolution or relief requested, and the facts supporting the resolution or relief requested;
- d. The particular provisions of the statutes and rules involved;
- e. A description of the attempts made to informally resolve the issues involved in the complaint or petition;
- f. All documentation relied on to support the facts alleged in the complaint or petition and the requested resolution or relief; and
- g. The name, address, telephone number, contact person and attorney, if any, for the other railroad or public utility involved and a statement that the complaint or petition was served on the other railroad or public utility involved and the consumer advocate, the method of service, and the date served.

42.18(4) Electronic filing required. Complaints and petitions for relief shall be filed in the commission's electronic filing system as described in 199—Chapter 14.

42.18(5) Expedited timeline. The commission recognizes that the parties will ordinarily require a swift decision. Therefore, the shortened time limits applicable to expedited proceedings in 199—Chapter 7 shall apply to contested cases brought under this chapter.

These rules are intended to implement Iowa Code sections 476.1, 476.1A, 476.1B, and 476.27.

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The Administrative Code Editor provides this informational notice that beginning with the July 10, 2024, issue of the Iowa Administrative Bulletin and the Iowa Administrative Code Supplement, the Legislative Services Agency is transitioning to new document processing software for these publications. Nonsubstantive changes to the style and format of these publications, as well as the Iowa Administrative Code, can be expected as a result of this transition. While the software has been tested extensively, errors resulting from this transition may still occur. To report any errors that may result from this transition, please contact the Publications Editing Office at AdminCode@legis.iowa.gov or 515.281.3355.